THE NONPROFIT HEALTH CARE CORPORATION REFORM ACT
Act 350 of 1980

AN ACT to provide for the incorporation of nonprofit health care corporations; to provide their rights, powers, and immunities; to prescribe the powers and duties of certain state officers relative to the exercise of those rights, powers, and immunities; to prescribe certain conditions for the transaction of business by those corporations in this state; to define the relationship of health care providers to nonprofit health care corporations and to specify their rights, powers, and immunities with respect thereto; to provide for a Michigan caring program; to provide for the regulation and supervision of nonprofit health care corporations by the commissioner of insurance; to prescribe powers and duties of certain other state officers with respect to the regulation and supervision of nonprofit health care corporations; to provide for the imposition of a regulatory fee; to regulate the merger or consolidation of certain corporations; to prescribe an expeditious and effective procedure for the maintenance and conduct of certain administrative appeals relative to provider class plans; to provide for certain administrative hearings relative to rates for health care benefits; to provide for certain causes of action; to prescribe penalties and to provide civil fines for violations of this act; and to repeal certain acts and parts of acts.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1991, Act 60, Imd. Eff. June 27, 1991;—Am. 1994, Act 169, Imd. Eff. June 17, 1994.

Compiler's note: For transfer of the Department of Insurance and Office of the Commissioner on Insurance from the Department of Licensing and Regulation to the Department of Commerce, see E.R.O. No. 1991-9, compiled at § 338.3501 of the Michigan Compiled Laws.

For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at § 445.2003 of the Michigan compiled laws.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

The People of the State of Michigan enact:

PART 1

550.1101 Short title.

Sec. 101. This act shall be known and may be cited as “the nonprofit health care corporation reform act”.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Constitutionality: Procedural fairness is required by the due process clause before governmental action drastically alters essential terms of the contract between nonprofit group health care plans and hospitals and nursing homes providing health care services; however, the guarantee of procedural due process does not necessarily require an adversary proceeding. Convalescent Center v. Blue Cross, 414 Mich. 247, 324 N.W.2d 851 (1982).

Administrative hearings under the Administrative Procedures Act, however informal, comport with the procedural fairness required by due process in the absence of an explicit statutory requirement that a contested evidentiary hearing be held. Convalescent Center v. Blue Cross, 414 Mich. 247, 324 N.W.2d 851 (1982).

This act is unconstitutional in the following three particulars:

(1) The act's provision for an actuary panel to resolve risk factor disputes is an unconstitutional delegation of legislative authority in that it lacks adequate standards (§ 550.1205(6)).

(2) The statutory restrictions on administrative services only (ASO) contracts violate equal protection of the laws insofar as they result in arbitrary and discriminatory treatment of health care corporations vis-a-vis commercial insurers (§§ 550.1104(3), 550.1211, 550.1414a, 550.1415, and 550.1607(1)).

(3) The commissioner's authority to issue a cease and desist order based on probable cause against a health care corporation for noncompliance with the act establishes an improper burden of proof (§ 550.1402(7)).

The Supreme Court ruling on these three areas of this act does not affect the constitutionality of the remainder of the act. Where, as here, the unconstitutional provisions are easily severable, the remainder of the act need not be affected. Blue Cross and Blue Shield of Michigan v. Governor, 422 Mich. 1 (1985).

Compiler's note: For transfer of the Department of Insurance and Office of the Commissioner on Insurance from the Department of Licensing and Regulation to the Department of Commerce, see E.R.O. No. 1991-9, compiled at § 338.3501 of the Michigan Compiled Laws.

For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at § 445.2003 of the Michigan compiled laws.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1102 Legislative intent and policy.

Sec. 102. (1) It is the purpose of and intent of this act, and the policy of the legislature, to promote an appropriate distribution of health care services for all residents of this state, to promote the progress of the science and art of health care in this state, and to assure for nongroup and group subscribers, reasonable access to, and reasonable cost and quality of, health care services, in recognition that the health care financing system is an essential part of the general health, safety, and welfare of the people of this state. Each corporation subject to this act is declared to be a charitable and benevolent institution and its funds and property shall be exempt from taxation by this state or any political subdivision of this state.

(2) It is the intention of the legislature that this act shall be construed to provide for the regulation and supervision of nonprofit health care corporations by the commissioner of insurance so as to secure for all of the people of this state who apply for a certificate, the opportunity for access to health care services at a fair and reasonable price.

(3) It is the public policy of this state that, in the interest of facilitating access to health care services at a fair and reasonable price, an alternate, expeditious, and effective procedure for the resolution of issues and the maintenance of administrative appeals relative to provider class plans be established and utilized, and to that end, the provisions of this act regarding administrative review of those provider class plans shall be construed so as to minimize uncertainty and delays.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1103 Meanings of words and phrases.

Sec. 103. For the purposes of this act, the words and phrases defined in sections 104 to 108 shall have the meanings ascribed to them in those sections.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1104 Definitions; A to C.

Sec. 104. (1) "Administrative procedures act" means the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, as amended, being sections 24.201 to 24.328 of the Michigan Compiled Laws, or a successor act.

(2) "Bargaining representative" means a representative designated or selected by a majority of employees for the purposes of collective bargaining in respect to rates of pay, wages, hours of employment, or other conditions of employment relative to the employees represented.

(3) "Certificate" means a contract between a health care corporation and a subscriber or a group of subscribers under which health care benefits are provided to members. A certificate includes any approved riders amending the contract.

(4) "Collective bargaining agreement" means an agreement entered into between the employer and the bargaining representative of its employees, and includes those agreements entered into on behalf of groups of employers with the bargaining representative of their employees pursuant to the national labor relations act, chapter 372, 49 Stat. 449, 29 U.S.C. 151 to 158 and 159 to 169, under Act No. 176 of the Public Acts of 1939, as amended, being sections 423.1 to 423.30 of the Michigan Compiled Laws, or under Act No. 336 of the Public Acts of 1947, as amended, being sections 423.201 to 423.216 of the Michigan Compiled Laws.

(5) "Commissioner" means the commissioner of insurance. Commissioner includes an authorized designee of the commissioner, if written notice of the delegation of authority has been given as provided in section 601.

(6) "Contingency reserve" means the sum of all assets minus the sum of all liabilities of a health care corporation, as shown in the annual financial statement filed under section 602.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1993, Act 127, Imd. Eff. July 21, 1993.

Constitutionality: This act is unconstitutional in the following three particulars:

The Supreme Court ruling on these three areas of this act does not affect the constitutionality of the remainder of the act. Where, as here, the unconstitutional provisions are easily severable, the remainder of the act need not be affected. Blue Cross and Blue Shield of Michigan v. Governor, 422 Mich. 1 (1985).

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1105 Definitions; H.

Sec. 105. (1) "Health care benefit" means the right under a certificate to have payment made by a health care corporation for a specified health care service, regardless of whether or not the payment is made pursuant to an administrative services only or cost-plus arrangement.

(2) "Health care corporation" means a nonprofit hospital service corporation, medical care corporation, or a consolidated hospital service and medical care corporation incorporated or reincorporated under this act, or incorporated or consolidated under former Act No. 108 or 109 of the Public Acts of 1939.

(3) "Health care facility" means a facility or agency as defined in section 22104 of Act No. 368 of the Public Acts of 1978, being section 333.22104 of the Michigan Compiled Laws, and includes a home health agency, or other facility with the approval of the commissioner.

(4) "Health care provider" or "provider", except as provided in section 301(8)(a), means a health care facility; a person licensed, certified, or registered under parts 161 to 182 of Act No. 368 of the Public Acts of 1978, as amended, being sections 333.16101 to 333.18237 of the Michigan Compiled Laws; any other person or facility, with the approval of the commissioner, who or which meets the standards set by the health care corporation for all contracting providers; and, for purposes of section 414a, any person or facility who or which provides intermediate or outpatient care for substance abuse, as defined in section 414a.

(5) "Health care services" means services provided, ordered, or prescribed by a health care provider, including health and rehabilitative services and medical supplies, medical and rehabilitative services and medical supplies, medical prosthetics and devices, and medical services ancillary or incidental to the provision of those services.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1980, Act 430, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1106 Definitions; L to O.

Sec. 106. (1) "Large subscriber group" means a group of 10,000 or more subscribers.

(2) "Medium subscriber group" means a group of 150 or more subscribers, but less than 10,000 subscribers.

(3) "Member", except as used in parts 2 and 3, means a subscriber, a dependent of a subscriber, or any other individual entitled to receive health care benefits under a nongroup or group certificate.

(4) "Nongroup subscriber" means an individual subscriber who is not enrolled as a subscriber through any subscriber group.

(5) "Objectives" means an expected achievement level by a health care corporation of the goals provided in section 504, for a provider class. Insofar as is reasonably practicable, objectives shall be capable of quantitative measurement.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1107 Definitions; P.

Sec. 107. (1) "Participating provider" means a provider that has entered into a participating contract with a health care corporation and that meets the standards set by the corporation for that class of providers.

(2) "Participating contract" means an agreement, contract, or other arrangement under which a provider agrees to accept the payment of the health care corporation as payment in full for health care services or parts of health care services covered under a certificate, as provided for in section 502(1).

(3) "Person" means an individual, corporation, partnership, organization, or association.

(4) "Personal data" means a document incorporating medical or surgical history, care, treatment, or service; or any similar record, including an automated or computer accessible record, relative to a member, which is maintained or stored by a health care corporation.

(5) "Proposed rate" means any of the following:

(a) A proposed increase or decrease in the rates to be charged to nongroup subscribers.

(b) For group subscribers, any proposed changes in the methodology or definitions of any rating system, formula, component, or factor subject to prior approval by the commissioner.

(c) A proposed increase or decrease in deductible amounts or coinsurance percentages.

(d) A proposed extension of benefits, additional benefits, or a reduction or limitation in benefits.

(e) A review pursuant to section 608(2).

(6) "Provider class" means classes of providers, as defined in section 105(4), that have a provider contract or a

reimbursement arrangement with a health care corporation to render health care services to subscribers, as those classes are established by the corporation.

(7) "Provider class plan" or "plan" means a document containing a reimbursement arrangement and objectives for a provider class, and, in the case of those providers with which a health care corporation contracts, provisions that are included in that contract.

(8) "Provider contract" or "contract" means an agreement between a provider and a health care corporation that contains provisions to implement the provider class plan.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1108 Definitions; R, S.

Sec. 108. (1) "Reimbursement arrangement" means policies, practices, and methods by which a health care corporation makes payments to a provider to implement the provider class plan.

(2) "Small subscriber group" means a group of less than 150 subscribers.

(3) "Subscriber" means an individual who contracts for health care benefits, either individually or through a group, with a health care corporation. Subscriber includes an individual whose contract contains an administrative services only or cost-plus arrangement authorized under section 207(1)(g).

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

PART 2

550.1201 Health care corporation; incorporation; number of persons; payment of cash or other material benefit to subscriber; applicable laws; charitable and benevolent institution; exemption from taxation; certificate of authority; health care benefits and certificates.

Sec. 201. (1) A health care corporation shall not be incorporated in this state except under this act.

(2) Not less than 7 persons, all of whom shall be residents of this state, may form a health care corporation under this act for the purpose of providing 1 or more health care benefits at the expense of the corporation to persons or groups of persons who become subscribers to the plan, under certificates which will entitle each subscriber to certain health care services by providers with which the corporation has contracted for that purpose.

(3) A certificate shall not provide for the payment of cash or any other material benefit to a subscriber or the estate of a subscriber on account of death, illness, or injury except where payment is made to a subscriber for health care services by a provider who has not entered into a participating contract with the corporation or to reimburse a subscriber who has made, or is obligated to make, payment directly to a provider.

(4) A health care corporation shall not be subject to the laws of this state with respect to insurance corporations, except as provided in this act. A health care corporation shall not be subject to the laws of this state with respect to corporations generally.

(5) A health care corporation subject to this act is declared to be a charitable and benevolent institution, and its funds and property shall be exempt from taxation by this state or any political subdivision of this state.

(6) A person shall not act as a health care corporation or issue a certificate except as authorized by and pursuant to a certificate of authority granted to the person by the commissioner pursuant to this act.

(7) A health care corporation shall provide only the kinds of health care benefits and certificates authorized by this act. A health care corporation shall not make or issue a certificate relative to health care benefits except as approved or otherwise authorized under this act.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1202 Articles of incorporation; contents; number; forms; examination and certification by attorney general; fees.

Sec. 202. (1) Persons associating to form a health care corporation under this act shall subscribe to articles of incorporation that shall contain all of the following:

(a) The names and addresses of the incorporators.

(b) The location of the principal office of the corporation for the transaction of business in this state.

(c) The name by which the corporation shall be known and all assumed names under which the corporation does business. The corporate name shall not include the words insurance, casualty, surety, health and accident, mutual, or other words descriptive of the insurance or surety business, and shall not be so similar to the name of an insurance or surety company doing business in this or other states at the time of incorporation so as to tend, in the judgment of the commissioner, to create confusion in identity with that insurance or surety company.

(d) The purposes of the corporation, which shall be:

(*i*) To provide health care benefits.

(*ii*) To secure for all of the people of this state who apply for a certificate the opportunity for access to coverage for health care services at a fair and reasonable price.

(*iii*) To assure for nongroup and group subscribers reasonable access to, and reasonable cost and quality of, health care services.

(*iv*) To achieve the goals of the corporation relative to access, quality, and cost of health care services, as prescribed in section 504.

(*v*) To offer supplemental coverage to all medicare enrollees as provided in part 4A.

(*vi*) If under contract to serve as fiscal intermediary for the federal medicare program, to do all of the following:

(A) Carry out its contractual responsibilities efficiently, including the timely processing and payment of claims.

(B) Actively represent, in negotiations with the federal government and with providers of medical, hospital, and other health services for which benefits are provided under the federal medicare program, the interests of senior citizens as they relate to cost and quality of, and access to, health care services and administration of the program.

(*vii*) To engage in activity otherwise authorized by this act, within the purposes for which corporations may be organized under this act.

(e) The term of existence of the corporation, which may be in perpetuity.

(f) The time for the holding of the annual meeting of the corporation.

(g) Other terms and conditions not inconsistent with this act, necessary for the conduct of the affairs of the corporation.

(2) The articles shall be in triplicate and upon proper forms as prescribed by the commissioner.

(3) Before the articles or amendments to the articles are effective for any purpose, they shall be submitted to the attorney general for examination. If the attorney general finds the articles or amendments to the articles to be in compliance with this act, the attorney general shall certify this finding to the commissioner. The articles or amendments shall be effective at the time certified by the attorney general.

(4) Each health care corporation shall pay a fee of $250.00 to the attorney general for the examination of its articles of incorporation, or $100.00 for the examination of amendments to the articles of incorporation. Each health care corporation shall pay a filing fee of $100.00 to the commissioner for filing its articles of incorporation or $50.00 for the filing of amendments to the articles of incorporation. The fees prescribed in this subsection shall be deposited in the state treasury and credited to the general fund of the state.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1988, Act 102, Imd. Eff. Apr. 11, 1988;—Am. 1994, Act 40, Imd. Eff. Mar. 14, 1994.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1203 Amendment or restatement of articles; review; approval.

Sec. 203. By action of its board of directors, a health care corporation may integrate into a single instrument the provisions of its articles of incorporation which are then in effect and operative, as theretofore amended. If the restated articles restate and integrate and also further amend the articles, they shall also be adopted by the board of directors. Any amendment or restatement of the articles shall be subject to review, approval, or both, as provided in section 202(3) or 701, as applicable.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1204 Filing of statements and documents; examination; investigation; additional information; conditions; duties of commissioner.

Sec. 204. (1) Before entering into contracts or securing applications of subscribers, the persons incorporating a health care corporation shall file all of the following in the office of the commissioner:

(a) Three copies of the articles of incorporation, with the certificate of the attorney general required under section 202(3) attached.

(b) A statement showing in full detail the plan upon which the corporation proposes to transact business.

(c) A copy of all certificates to be issued to subscribers.

(d) A copy of the financial statements of the corporation.

(e) Proposed advertising to be used in the solicitation of certificates for subscribers.

(f) A copy of the bylaws.

(g) A copy of all proposed contracts and reimbursement methods.

(2) The commissioner shall examine the statements and documents filed under subsection (1), may conduct any investigation that he or she considers necessary, may request additional oral and written information from the incorporators, and may examine under oath any persons interested in or connected with the proposed health care corporation. The commissioner shall ascertain whether all of the following conditions are met:

(a) The solicitation of certificates will not work a fraud upon the persons solicited by the corporation.

(b) The rates to be charged and the benefits to be provided are adequate, equitable, and not excessive, as defined in section 609.

(c) The amount of money actually available for working capital is sufficient to carry all acquisition costs and operating expenses for a reasonable period of time from the date of issuance of the certificate of authority, and is not less than $500,000.00 or a greater amount, if the commissioner considers it necessary.

(d) The amounts contributed as the working capital of the corporation are payable only out of amounts in excess of minimum required reserves of the corporation.

(e) Adequate and unimpaired surplus is provided, as determined under section 204a.

(3) If the commissioner finds that the conditions prescribed in subsection (2) are met, the commissioner shall do all of the following:

(a) Return to the incorporators 1 copy of the articles of incorporation, certified for filing with the director of the department of consumer and industry services or of any other agency or department authorized by law to administer the business corporation act, 1972 PA 284, MCL 450.1101 to 450.2098, or his or her designated representative, and 1 copy of the articles of incorporation certified for the records of the corporation itself.

(b) Retain 1 copy of the articles of incorporation for the commissioner's office files.

(c) Deliver to the corporation a certificate of authority to commence business and to issue certificates that have been approved by the commissioner, or that are exempted from prior approval pursuant to section 607(2) or (8), entitling subscribers to certain health care benefits.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 2003, Act 59, Eff. July 23, 2003.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1204a Unimpaired surplus.

Sec. 204a. (1) A health care corporation shall possess and maintain unimpaired surplus in an amount determined adequate by the commissioner to comply with section 403 of the insurance code of 1956, 1956 PA 218, MCL 500.403. The commissioner shall follow the risk-based capital requirements as developed by the national association of insurance commissioners in order to determine whether a health care corporation is in adequate compliance with section 403 of the insurance code of 1956, 1956 PA 218, MCL 500.403.

(2) If a health care corporation files a risk-based capital report that indicates that its surplus is less than the amount determined adequate by the commissioner under subsection (1), the health care corporation shall prepare and submit a plan for remedying the deficiency in accordance with risk-based capital requirements adopted by the commissioner. Among the remedies that a health care corporation may employ are planwide viability contributions to surplus by subscribers.

(3) If contributions for planwide viability under subsection (2) are employed, those contributions shall be made in accordance with the following:

(a) If the health care corporation's surplus is less than 200% but more than 150% of the authorized control level under risk-based capital requirements, the maximum contribution rate shall be 0.5% of the rate charged to subscribers for the benefits provided.

(b) If the health care corporation's surplus is 150% or less than the authorized control level under risk-based capital requirements, the maximum contribution rate shall be 1% of the rate charged to subscribers for the benefits provided.

(c) The actual contribution rate charged is subject to the commissioner's approval.

(4) As used in subsection (3), "authorized control level" means the number determined under the risk-based capital formula in accordance with the instructions developed by the national association of insurance commissioners and adopted by the commissioner.

(5) Subject to this subsection, a health care corporation shall not maintain surplus in an amount that equals or is greater than 200% of the authorized control level under risk-based capital requirements multiplied by 5. If a health care corporation files a risk-based capital report that indicates that its surplus is more than the allowable maximum surplus permitted under this subsection for 2 successive calendar years, the health care corporation shall file a plan for approval by the commissioner to adjust its surplus to a level below the allowable maximum surplus. If the commissioner disapproves the health care corporation's plan, the commissioner shall formulate an alternate plan and forward the alternate plan to the health care corporation. The health care corporation shall begin implementation of the plan immediately upon receipt of approval of its plan by the commissioner or upon receipt of the commissioner's alternate plan.

History: Add. 2003, Act 59, Eff. July 23, 2003.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1205 Repealed. 2003, Act 59, Eff. July 23, 2003.

Compiler's note: The repealed section pertained to accounting and filing practices of health care corporation.
Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1205a Actuarial practices and accounting principles; financial report.

Sec. 205a. A health care corporation shall report financial information in conformity with sound actuarial practices and statutory accounting principles in the same manner as designated by the commissioner for other carriers pursuant to section 438(2) of the insurance code of 1956, 1956 PA 218, MCL 500.438. Approved permitted practices for the sole purpose of effectuating the transfer to statutory accounting principles under this section may be used by a health care corporation until January 1, 2007.

History: Add. 2003, Act 59, Eff. July 23, 2003.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1206 Funds, property, and business of health care corporation; investments; insurance; prepaid health care benefits.

Sec. 206. (1) The funds and property of a health care corporation shall be acquired, held, and disposed of only for the lawful purposes of the corporation and for the benefit of the subscribers of the corporation as a whole. A health care corporation shall only transact business, receive, collect, and disburse money, and acquire, hold, protect, and convey property, that is properly within the scope of the purposes of the corporation as specifically set forth in section 202(1)(d), for the benefit of the subscribers of the corporation as a whole, and consistent with this act.

(2) The funds of a health care corporation shall be invested only in securities permitted by the laws of this state for the investments of assets of life insurance companies, as described in chapter 9 of the insurance code of 1956, 1956 PA 218, MCL 500.901 to 500.947.

(3) Without regard to the limitation in subsection (2), up to 2% of the assets of the health care corporation may be invested in venture-type investments. For purposes of calculating adequate and unimpaired surplus under section 204a, a venture-type investment shall be carried on the books of a health care corporation at the original acquisition cost, and losses may only be realized as an offset against gains from venture-type investments. All venture-type investments under this subsection shall provide employment or capital investment primarily within this state. Each investment under this subsection is subject to prior approval by the board of directors. As used in this subsection, "venture-type investments" include:

(a) Common stock, preferred stock, limited partnerships, or similar equity interests acquired from the issuer subject to a provision barring resale without consent of the issuer for 5 years from the date of acquisition by the corporation.

(b) Unsecured debt instruments that are either convertible into equity or have equity acquisition rights. These debt instruments shall be subordinated by their terms to all borrowings of the issuer from other institutional lenders and shall have no part amortized during the first 5 years.

(4) A health care corporation shall not market or transact, as defined in sections 402a and 402b of the insurance code of 1956, 1956 PA 218, MCL 500.402a and 500.402b, any type of insurance described in chapter 6 of the

insurance code of 1956, 1956 PA 218, MCL 500.600 to 500.644. This subsection shall not be construed to prohibit the provision of prepaid health care benefits.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 2003, Act 59, Eff. July 23, 2003.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1207 Powers of health care corporation; interests of senior citizens; validity of corporate acts.

Sec. 207. (1) A health care corporation, subject to any limitation provided in this act, in any other statute of this state, or in its articles of incorporation, may do any or all of the following:

(a) Contract to provide computer services and other administrative consulting services to 1 or more providers or groups of providers, if the services are primarily designed to result in cost savings to subscribers.

(b) Engage in experimental health care projects to explore more efficient and economical means of implementing the corporation's programs, or the corporation's goals as prescribed in section 504 and the purposes of this act, to develop incentives to promote alternative methods and alternative providers, including nurse midwives, nurse anesthetists, and nurse practitioners, for delivering health care, including preventive care and home health care.

(c) For the purpose of providing health care services to employees of this state, the United States, or an agency, instrumentality, or political subdivision of this state or the United States, or for the purpose of providing all or part of the costs of health care services to disabled, aged, or needy persons, contract with this state, the United States, or an agency, instrumentality, or political subdivision of this state or the United States.

(d) For the purpose of administering any publicly supported health benefit plan, accept and administer funds, directly or indirectly, made available by a contract authorized under subdivision (c), or made available by or received from any private entity.

(e) For the purpose of administering any publicly supported health benefit plan, subcontract with any organization that has contracted with this state, the United States, or an agency, instrumentality, or political subdivision of this state or the United States, for the administration or furnishing of health services or any publicly supported health benefit plan.

(f) Provide administrative services only and cost-plus arrangements for the federal medicare program established by parts A and B of title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395c to 1395i, 1395i-2 to 1395i-5, 1395j to 1395t, 1395u to 1395w, and 1395w-2 to 1395w-4; for the federal medicaid program established under title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396r-6, and 1396r-8 to 1396v; for title V of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 701 to 704 and 705 to 710; for the program of medical and dental care established by the military medical benefits amendments of 1966, Public Law 85-861, 80 Stat. 862; for the Detroit maternity and infant care--preschool, school, and adolescent project; and for any other health benefit program established under state or federal law.

(g) Provide administrative services only and cost-plus arrangements for any noninsured health benefit plan, subject to the requirements of sections 211 and 211a.

(h) Establish, own, and operate a health maintenance organization, subject to the requirements of the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302.

(i) Guarantee loans for the education of persons who are planning to enter or have entered a profession that is licensed, certified, or registered under parts 161 to 182 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18237, and has been identified by the commissioner, with the consultation of the office of health and medical affairs in the department of management and budget, as a profession whose practitioners are in insufficient supply in this state or specified areas of this state and who agree, as a condition of receiving a guarantee of a loan, to work in this state, or an area of this state specified in a listing of shortage areas for the profession issued by the commissioner, for a period of time determined by the commissioner.

(j) Receive donations to assist or enable the corporation to carry out its purposes, as provided in this act.

(k) Bring an action against an officer or director of the corporation.

(*l*) Designate and maintain a registered office and a resident agent in that office upon whom service of process may be made.

(m) Sue and be sued in all courts and participate in actions and proceedings, judicial, administrative, arbitrative, or otherwise, in the same cases as natural persons.

(n) Have a corporate seal, alter the seal, and use it by causing the seal or a facsimile to be affixed, impressed, or reproduced in any other manner.

(o) Subject to chapter 9 of the insurance code of 1956, 1956 PA 218, MCL 500.901 to 500.947, invest and

reinvest its funds and, for investment purposes only, purchase, take, receive, subscribe for, or otherwise acquire, own, hold, vote, employ, sell, lend, lease, exchange, transfer, or otherwise dispose of, mortgage, pledge, use, and otherwise deal in and with, bonds and other obligations, shares, or other securities or interests issued by entities other than domestic, foreign, or alien insurers, as defined in sections 106 and 110 of the insurance code of 1956, 1956 PA 218, MCL 500.106 and 500.110, whether engaged in a similar or different business, or governmental or other activity, including banking corporations or trust companies. However, a health care corporation may purchase, take, receive, subscribe for, or otherwise acquire, own, hold, vote, employ, sell, lend, lease, exchange, transfer, or otherwise dispose of bonds or other obligations, shares, or other securities or interests issued by a domestic, foreign, or alien insurer, so long as the activity meets all of the following:

(*i*) Is determined by the attorney general to be lawful under section 202.

(*ii*) Is approved in writing by the commissioner as being in the best interests of the health care corporation and its subscribers.

(*iii*) For an activity that occurred before the effective date of the amendatory act that added subparagraph (*iv*), will not result in the health care corporation owning or controlling 10% or more of the voting securities of the insurer or will not otherwise result in the health care corporation having control of the insurer, either before or after the effective date of the amendatory act that added subparagraph (*iv*). As used in this subparagraph and subparagraph (*iv*), "control" means that term as defined in section 115 of the insurance code of 1956, 1956 PA 218, MCL 500.115.

(*iv*) Subject to section 218 and beginning on the effective date of the amendatory act that added this subparagraph, will not result in the health care corporation owning or controlling part or all of the insurer unless the transaction satisfies chapter 13 of the insurance code of 1956, 1956 PA 218, MCL 500.1301 to 500.1379, and the insurer being acquired is only authorized to sell disability insurance as defined under section 606 of the insurance code of 1956, 1956 PA 218, MCL 500.606, or under a statute or regulation in the insurer's domiciliary jurisdiction that is substantially similar to section 606 of the insurance code of 1956, 1956 PA 218, MCL 500.606.

(p) Purchase, receive, take by grant, gift, devise, bequest or otherwise, lease, or otherwise acquire, own, hold, improve, employ, use and otherwise deal in and with, real or personal property, or an interest therein, wherever situated.

(q) Sell, convey, lease, exchange, transfer or otherwise dispose of, or mortgage or pledge, or create a security interest in, any of its property, or an interest therein, wherever situated.

(r) Borrow money and issue its promissory note or bond for the repayment of the borrowed money with interest.

(s) Make donations for the public welfare, including hospital, charitable, or educational contributions that do not significantly affect rates charged to subscribers.

(t) Participate with others in any joint venture with respect to any transaction that the health care corporation would have the power to conduct by itself.

(u) Cease its activities and dissolve, subject to the commissioner's authority under section 606(2).

(v) Make contracts, transact business, carry on its operations, have offices, and exercise the powers granted by this act in any jurisdiction, to the extent necessary to carry out its purposes under this act.

(w) Have and exercise all powers necessary or convenient to effect any purpose for which the corporation was formed.

(x) Notwithstanding subdivision (o) or any other provision of this act, establish, own, and operate a domestic stock insurance company only for the purpose of acquiring, owning, and operating the state accident fund pursuant to chapter 51 of the insurance code of 1956, 1956 PA 218, MCL 500.5100 to 500.5114, so long as all of the following are met:

(*i*) For insurance products and services the insurer whether directly or indirectly only transacts worker's compensation insurance and employer's liability insurance, transacts disability insurance limited to replacement of loss of earnings, and acts as an administrative services organization for an approved self-insured worker's compensation plan or a disability insurance plan limited to replacement of loss of earnings and does not transact any other type of insurance notwithstanding the authorization in chapter 51 of the insurance code of 1956, 1956 PA 218, MCL 500.5100 to 500.5114. This subparagraph does not preclude the insurer from providing either directly or indirectly noninsurance products and services as otherwise provided by law.

(*ii*) The activity is determined by the attorney general to be lawful under section 202.

(*iii*) The health care corporation does not directly or indirectly subsidize the use of any provider or subscriber information, loss data, contract, agreement, reimbursement mechanism or arrangement, computer system, or health care provider discount to the insurer.

(*iv*) Members of the board of directors, employees, and officers of the health care corporation are not, directly or

indirectly, employed by the insurer unless the health care corporation is fairly and reasonably compensated for the services rendered to the insurer if those services were paid for by the health care corporation.

(*v*) Health care corporation and subscriber funds are used only for the acquisition from the state of Michigan of the assets and liabilities of the state accident fund.

(*vi*) Health care corporation and subscriber funds are not used to operate or subsidize in any way the insurer including the use of such funds to subsidize contracts for goods and services. This subparagraph does not prohibit joint undertakings between the health care corporation and the insurer to take advantage of economies of scale or arm's-length loans or other financial transactions between the health care corporation and the insurer.

(2) In order to ascertain the interests of senior citizens regarding the provision of medicare supplemental coverage, as described in section 202(1)(d)(*v*), and to ascertain the interests of senior citizens regarding the administration of the federal medicare program when acting as fiscal intermediary in this state, as described in section 202(1)(d)(*vi*), a health care corporation shall consult with the office of services to the aging and with senior citizens' organizations in this state.

(3) An act of a health care corporation, otherwise lawful, is not invalid because the corporation was without capacity or power to do the act. However, the lack of capacity or power may be asserted:

(a) In an action by a director or a member of the corporate body against the corporation to enjoin the doing of an act.

(b) In an action by or in the right of the corporation to procure a judgment in its favor against an incumbent or former officer or director of the corporation for loss or damage due to an unauthorized act of that officer or director.

(c) In an action or special proceeding by the attorney general to enjoin the corporation from the transacting of unauthorized business, to set aside an unauthorized transaction, or to obtain other equitable relief.

(4) A health care corporation shall not condition the sale or vary the terms or conditions of any product sold by the corporation or by a subsidiary of the corporation by requiring the purchase of any other product from the corporation or from a subsidiary of the corporation.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1989, Act 260, Imd. Eff. Dec. 26, 1989;—Am. 1993, Act 127, Imd. Eff. July 21, 1993;—Am. 1993, Act 201, Imd. Eff. Oct. 19, 1993;—Am. 1999, Act 210, Imd. Eff. Dec. 21, 1999;—Am. 2003, Act 59, Eff. July 23, 2003.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1208 Action by member; complaint.

Sec. 208. (1) An action may be brought in the right of a health care corporation to procure a judgment in its favor, by a member of the corporate body.

(2) In such an action, the complaint shall allege:

(a) That the plaintiff is a member of the corporate body at the time of bringing the action, and that he or she was a member of the corporate body at the time of the transaction of which he or she complains.

(b) With particularity, the effort of the plaintiff to secure the initiation of the action by the board or the reasons for not making the effort.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1209 Action by member; discontinuance, compromise, or settlement; notice; expense.

Sec. 209. An action authorized by section 208 shall not be discontinued, compromised, or settled without approval by the court having jurisdiction of the action. If the court determines that the interest of the members of the corporate body or of any component thereof will be substantially affected by the discontinuance, compromise, or settlement, the court may direct that notice, by publication or otherwise, be given to the members of the corporate body or any component thereof, whose interests it determines will be so affected. If notice is so directed to be given, the court may determine which 1 or more of the parties to the action shall bear the expense of giving the notice, in an amount which the court determines and finds reasonable under the circumstances. The amount of this expense shall be awarded as special costs of the action and shall be recoverable in the same manner as statutory taxable costs.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1210 Action by member; reasonable expenses; attorney's fees.

Sec. 210. (1) If an action brought in the right of the corporation is successful, in whole or in part, or if anything is received by the plaintiff or a claimant as a result of a judgment, compromise, or settlement of an action or claim, the court may award the plaintiff or claimant reasonable expenses, including reasonable attorney's fees, and shall direct him or her to account to the corporation for the remainder of the proceeds so received by him or her. This section does not apply to a judgment rendered for the benefit of an injured corporate body member only and limited to a recovery of the loss or damage sustained by him or her.

(2) In an action brought in the right of the corporation by a member of the corporate body, the court having jurisdiction, upon final judgment and finding that the action was brought without reasonable cause, may require the plaintiff to pay to the parties named as defendants the reasonable expenses, including fees of attorneys, incurred by them in the defense of the action.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1211 Administrative services only and cost-plus arrangements; service contracts; fees; administrative costs; marketing policy; notice; coverage, rights, and obligations under collective bargaining agreement; liability of individual; report; "noninsured benefit plan" defined.

Sec. 211. (1) Pursuant to section 207(1)(g), a health care corporation may enter into service contracts containing an administrative services only or cost-plus arrangement. Except as otherwise provided in this section, a corporation shall not enter into a service contract containing an administrative services only or cost-plus arrangement for a noninsured benefit plan covering a group of less than 500 individuals, except that a health care corporation may continue an administrative services only or cost-plus arrangement with a group of less than 500, which arrangement is in existence in September of 1980. A corporation may enter into contracts containing an administrative services only or cost-plus arrangement for a noninsured benefit plan covering a group of less than 500 individuals if either the corporation makes arrangements for excess loss coverage or the sponsor of the plan that covers the individuals is liable for the plan's liabilities and is a sponsor of 1 or more plans covering a group of 500 or more individuals in the aggregate. The commissioner, upon obtaining the advice of the corporations subject to this act, shall establish the standards for the manner and amount of the excess loss coverage required by this subsection. It is the intent of the legislature that the excess loss coverage requirements be uniform as between corporations subject to this act and other persons authorized to provide similar services. The corporation shall offer in connection with a noninsured benefit plan a program of specific or aggregate excess loss coverage.

(2) Relative to actual administrative costs, fees for administrative services only and cost-plus arrangements shall be set in a manner that precludes cost transfers between subscribers subject to either of these arrangements and other subscribers of the health care corporation. Administrative costs for these arrangements shall be determined in accordance with the administrative costs allocation methodology and definitions filed and approved under part 6, and shall be expressed clearly and accurately in the contracts establishing the arrangements, as a percentage of costs rather than charges. This subsection shall not be construed to prohibit the inclusion, in fees charged, of contributions to adequate and unimpaired surplus as provided in section 204a.

(3) Before a health care corporation may enter into contracts containing administrative services only or cost-plus arrangements pursuant to section 207(1)(g), the board of directors of the corporation shall approve a marketing policy for these arrangements that is consistent with this section. The marketing policy may contain other provisions as the board considers necessary. The marketing policy shall be carried out by the corporation consistent with this act.

(4) A corporation providing services under a contract containing an administrative services only or cost-plus arrangement in connection with a noninsured benefit plan shall provide in its service contract a provision that the person contracting for the services in connection with a noninsured benefit plan shall notify each covered individual of what services are being provided; the fact that individuals are not insured or are not covered by a certificate from the corporation, or are only partially insured or are only partially covered by a certificate from the corporation, as the case may be; which party is liable for payment of benefits; and of future changes in benefits.

(5) A service contract containing an administrative services only arrangement between a corporation and a governmental entity not subject to the employee retirement income security act of 1974, Public Law 93-406, 88 Stat. 829, whose plan provides coverage under a collective bargaining agreement utilizing a policy or certificate issued by a carrier before the signing of the service contract, is void unless the governmental entity has provided the notice described in subsection (4) to the collective bargaining agent and to the members of the collective bargaining

unit not less than 30 days before signing the service contract. The voiding of a service contract under this subsection shall not relieve the governmental entity of any obligations to the corporation under the service contract.

(6) Nothing in this section shall be construed to permit an actionable interference by a corporation with the rights and obligations of the parties under a collective bargaining agreement.

(7) An individual covered under a noninsured benefit plan for which services are provided under a service contract authorized under subsection (1) is not liable for that portion of claims incurred and subject to payment under the plan if the service contract is entered into between an employer and a corporation, unless that portion of the claim has been paid directly to the covered individual.

(8) A corporation shall report with its annual statement the amount of business it has conducted as services provided under subsection (1) that are performed in connection with a noninsured benefit plan, and the commissioner shall transmit annually this information to the state treasurer. The commissioner shall submit to the legislature on April 1, 1994, a report detailing the impact of this section on employers and covered individuals, and similar activities under other provisions of law, and in consultation with the state treasurer the total financial impact on the state for the preceding legislative biennium.

(9) As used in this section, "noninsured benefit plan" or "plan" means a health benefit plan without coverage by a health care corporation, health maintenance organization, or insurer or the portion of a health benefit plan without coverage by a health care corporation, health maintenance organization, or insurer that has a specific or aggregate excess loss coverage.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1984, Act 181, Imd. Eff. July 3, 1984;—Am. 1993, Act 127, Imd. Eff. July 21, 1993;—Am. 2003, Act 59, Eff. July 23, 2003.

Constitutionality: This act is unconstitutional in the following three particulars:

(1) The act's provision for an actuary panel to resolve risk factor disputes is an unconstitutional delegation of legislative authority in that it lacks adequate standards (§ 550.1205(6)).

(2) The statutory restrictions on administrative services only (ASO) contracts violate equal protection of the laws insofar as they result in arbitrary and discriminatory treatment of health care corporations vis-a-vis commercial insurers (§§ 550.1104(3), 550.1211, 550.1414a, 550.1415, and 550.1607(1)).

(3) The commissioner's authority to issue a cease and desist order based on probable cause against a health care corporation for noncompliance with the act establishes an improper burden of proof (§ 550.1402(7)).

The Supreme Court ruling on these three areas of this act does not affect the constitutionality of the remainder of the act. Where, as here, the unconstitutional provisions are easily severable, the remainder of the act need not be affected. Blue Cross and Blue Shield of Michigan v. Governor, 422 Mich. 1 (1985).

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1211a Definitions; prohibited acts by corporation; processing claims for benefits on timely basis; claim form; notice to covered individuals; notice to corporation of complaint and proceedings contemplated; hearing; findings; order; violation of order; penalty; action and award of actual monetary damages; review; stay of enforcement.

Sec. 211a. (1) As used in this section:

(a) "Noninsured benefit plan" means a health benefit plan without coverage by a health care corporation, health maintenance organization, or insurer or the portion of a health benefit plan without coverage by a health care corporation, health maintenance organization, or insurer that has a specific or aggregate excess loss coverage.

(b) "Process a claim" means the services performed in connection with a claim for benefits including the disbursement of benefit amounts.

(2) A health care corporation providing services under section 211 shall not do any of the following:

(a) Misrepresent pertinent facts relating to coverage.

(b) Fail to acknowledge promptly or to act reasonably and promptly upon communications with respect to a claim for benefits.

(c) Fail to adopt and implement reasonable standards for the prompt investigation of a claim for benefits.

(d) Refuse to process claims without conducting a reasonable investigation based upon the available information.

(e) Fail to communicate affirmation or denial of coverage of a claim for benefits within a reasonable time after a claim has been received.

(f) Fail to attempt in good faith to promptly, fairly, and equitably process a claim for benefits.

(g) Knowingly compel covered individuals to institute litigation to recover amounts due under a benefit plan or certificate by offering substantially less than the amounts due.

(h) For the purpose of coercing a covered individual to accept a settlement or compromise in a claim, inform the covered individual of a corporation policy of appealing administrative hearing decisions that are in favor of covered

individuals.

(i) Delay the investigation or processing of a claim by requiring a covered individual, or the provider of services to the covered individual, to submit a preliminary claim and then requiring subsequent submission of a formal claim, seeking solely the duplication of a verification.

(j) Fail to promptly provide a reasonable explanation of the basis for denial or partial denial of a claim for benefits.

(k) Fail to promptly process a claim where liability has become reasonably clear under 1 portion of a benefit plan or certificate in order to influence a settlement under another portion of the benefit plan or certificate.

(*l*) Refuse to enter into a service contract, or refuse to provide services under a service contract because of race, color, creed, marital status, sex, national origin, residence, age, disability, or lawful occupation.

(3) A corporation providing services under section 211 in connection with a noninsured benefit plan shall not, in order to induce a person to contract or to continue to contract with the corporation for the provision of services under a service contract or certificate offered by the corporation; to induce a person to lapse, forfeit, or surrender a certificate or service contract issued by the corporation; or to induce a person to secure or terminate coverage with an insurer, health care corporation, health maintenance organization, or other person, directly or indirectly, do any of the following:

(a) Issue or deliver to the person money or any other valuable consideration.

(b) Offer to make or make an agreement relating to a service contract or certificate other than as plainly expressed in the service contract or certificate.

(c) Offer to give or pay, or give or pay, directly or indirectly, a rebate or adjustment of the rate payable on the service contract or certificate, or an advantage in the services thereunder, except as reflected in the rate and expressly provided in the service contract or certificate. Readjustment of the rate for services provided under the service contract or certificate may be made at the end of a contract or certificate year or contract or certificate period and may be made retroactive.

(d) Make, issue, or circulate, or cause to be made, issued, or circulated, an estimate, illustration, circular, or statement misrepresenting the terms of a service contract or certificate, the advantages provided thereunder, or the true nature thereof.

(e) Make a misrepresentation or incomplete comparison, whether oral or written, between service contracts or certificates of the corporation or between service contracts or certificates of the corporation and an insurer, hospital service corporation, health maintenance organization, or other person.

(4) A corporation providing services under section 211 in connection with a noninsured benefit plan shall process claims for benefits on a timely basis. If not paid on a timely basis, benefits payable to a covered individual shall bear simple interest from a date 60 days after a satisfactory claim form was received by the corporation, at a rate of 12% interest per annum. The interest shall be paid by the noninsured benefit plan in addition to, and at the time of payment of, the claim.

(5) A corporation providing services under section 211 in connection with a noninsured benefit plan shall specify in writing the materials that constitute a satisfactory claim form not later than 30 days after receipt of a claim, unless the claim is settled within 30 days. If a claim form is not supplied as to the entire claim, the amount supported by the claim form shall be considered to be paid on a timely basis if paid within 60 days after receipt of the claim form by the corporation.

(6) A corporation providing services under section 211 in connection with a noninsured benefit plan shall provide in its service contract a provision that the person contracting for the services in connection with a noninsured benefit plan shall notify each covered individual as to what services are being provided; the fact that individuals are not insured or are not covered by a certificate from the corporation, or are only partially insured or are only partially covered by a certificate from the corporation, as the case may be; which party is liable for payment of benefits; and of future changes in benefits.

(7) If the commissioner has probable cause to believe that a corporation is violating, or has violated subsection (2), indicating a persistent tendency to engage in conduct prohibited by that subsection, or has probable cause to believe that a corporation is violating, or has violated any other subsection of this section, he or she shall give written notice to the corporation, pursuant to the administrative procedures act, setting forth the general nature of the complaint against the corporation and the proceedings contemplated under this section. Before the issuance of a notice of hearing, the staff of the insurance bureau responsible for the matters that would be at issue in the hearing shall give the corporation an opportunity to confer and discuss the possible complaint and proceedings in person with the commissioner or a representative of the commissioner, and the matter may be disposed of summarily upon agreement of the parties. This subsection shall not be construed to diminish the right of a person to bring an action

for damages under this section.

(8) A hearing held pursuant to subsection (7) shall be held pursuant to the administrative procedures act. If, after the hearing, the commissioner determines that the corporation is violating, or has violated subsection (2), indicating a persistent tendency to engage in conduct prohibited by that subsection, or has violated or is violating any other subsection of this section, the commissioner shall reduce his or her findings and decision to writing, and shall issue and cause to be served upon the corporation a copy of the findings and an order requiring the corporation to cease and desist from engaging in the prohibited activity. In addition to a cease and desist order, the commissioner may order any of the following:

(a) Payment of a monetary penalty of not more than $500.00 for each violation but not to exceed an aggregate penalty of $5,000.00, unless the corporation knew or reasonably should have known it was in violation of this section, in which case the penalty shall not be more than $2,500.00 for each violation and shall not exceed an aggregate penalty of $25,000.00 for all violations committed in a 6-month period.

(b) Suspension or revocation of the corporation's license or certificate of authority if the corporation knowingly and persistently violated this section.

(c) Refund of any overcharges.

(9) A corporation that violates a cease and desist order of the commissioner issued under subsection (8), after notice and an opportunity for a hearing, and upon order of the commissioner, may be subject to a civil fine of not more than $10,000.00 for each violation.

(10) In addition to other remedies provided by law, an aggrieved covered individual may bring an action for actual monetary damages sustained as a result of a violation of this section. If successful on the merits, the covered individual shall be awarded actual monetary damages or $200.00, whichever is greater. If the corporation shows by a preponderance of the evidence that a violation of this section resulted from a bona fide error notwithstanding the maintenance of procedures reasonably adapted to avoid the error, the amount of recovery shall be limited to actual monetary damages.

(11) The filing of a petition for review does not stay enforcement of action pursuant to this section, but the commissioner may grant, or the appropriate court may order, a stay upon appropriate terms.

(12) The commissioner may at any time, by order, after notice and opportunity for hearing, reopen and alter, modify, or set aside, in whole or in part, an order issued by him or her under this section, when in his or her opinion conditions of fact or of law have so changed as to require that action or if the public interest shall so require.

History: Add. 1993, Act 127, Imd. Eff. July 21, 1993;—Am. 1998, Act 24, Imd. Eff. Mar. 12, 1998.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1212 Action without notice or lapse of time periods; waiver; attorney-in-fact.

Sec. 212. When, under this act or the articles of incorporation or bylaws of a health care corporation or by the terms of an agreement or instrument, a health care corporation or the board of directors of the health care corporation or any committee of the board may take action after notice to any person or after lapse of a prescribed period of time, the action may be taken without notice and without lapse of the period of time, if at any time before or after the action is completed the person entitled to notice or to participate in the action to be taken or, in case of a subscriber, by his or her attorney-in-fact, submits a signed waiver of those requirements. The attorney-in-fact may not be employed by, or receive substantial income from, the health care corporation.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1213 Indemnification.

Sec. 213. (1) A health care corporation may indemnify any person who was or is a party to, or is threatened to be made a party to, any threatened, pending, or completed action, suit, or proceeding, whether civil, criminal, administrative, or investigative, other than an action by or in the right of the health care corporation, by reason of the fact that he or she is or was a director, member of the corporate body, officer, employee, or agent of the health care corporation, or is or was serving at the request of the health care corporation as a director, officer, employee, or agent of another corporation, partnership, joint venture, trust, or other enterprise. This indemnification shall be against expenses, including attorneys' fees, judgments, fines, and amounts paid in settlement, actually and reasonably incurred by him or her in connection with the action, suit, or proceeding, if he or she acted in good faith and in a manner which he or she reasonably believed to be in, or not opposed to, the best interests of the health care

corporation, or its subscribers as a whole, and, with respect to any criminal action or proceeding, had no reasonable cause to believe his or her conduct was unlawful. The termination of any action, suit, or proceeding by judgment, order, settlement, conviction, or upon a plea of nolo contendere or its equivalent, shall not, of itself, create a presumption that the person did not act in good faith and in a manner which he or she reasonably believed to be in or not opposed to the best interests of the health care corporation, or its subscribers as a whole, and, with respect to any criminal action or proceeding, had reasonable cause to believe that his or her conduct was unlawful.

(2) A health care corporation may indemnify any person who was or is a party to, or is threatened to be made a party to, any threatened, pending, or completed action or suit by or in the right of the health care corporation to procure a judgment in its favor, by reason of the fact that he or she is or was a director, member of the corporate body, officer, employee, or agent of the health care corporation, or is or was serving at the request of the health care corporation as a director, officer, employee, or agent of another corporation, partnership, joint venture, trust, or other enterprise. This indemnification shall be against expenses, including attorneys' fees, actually and reasonably incurred by him or her in connection with the defense or settlement of the action or suit, if he or she acted in good faith and in a manner he or she reasonably believed to be in or not opposed to the best interests of the health care corporation, or its subscribers as a whole. However, indemnification shall not be made with respect to any claim, issue, or matter as to which the person has been adjudged to be liable for negligence or misconduct in the performance of his or her duty to the health care corporation unless, and only to the extent that, the court in which the action or suit was brought determines upon application that, despite the adjudication of liability, but in view of all circumstances of the case, the person is fairly and reasonably entitled to indemnity for those expenses which the court considers proper.

(3) To the extent that a director, member of the corporate body, officer, employee, or agent of a health care corporation has been successful on the merits or otherwise in defense of any action, suit, or proceeding referred to in subsection (1) or (2), or in defense of any claim, issue, or matter therein, he or she shall be indemnified against expenses, including attorneys' fees, actually and reasonably incurred by him or her in connection therewith.

(4) Any indemnification under subsection (1) or (2), unless ordered by a court, shall be made by the health care corporation only as authorized in the specific case, upon a determination that indemnification of the director, member of the corporate body, officer, employee, or agent is proper in the circumstances because he or she has met the applicable standard of conduct set forth in subsections (1) and (2). The determination shall be made in any of the following ways:

(a) By the board by a majority vote of a quorum consisting of directors who were not parties to the action, suit, or proceeding.

(b) If such a quorum is not obtainable, by independent legal counsel in a written opinion.

(5) Expenses incurred in defending a civil or criminal action, suit, or proceeding described in subsection (1) or (2) may be paid by the health care corporation in advance of the final disposition of the action, suit, or proceeding, as authorized in the manner provided in subsection (4), upon receipt of an undertaking by or on behalf of the director, member of the corporate body, officer, employee, or agent to repay that amount, unless it is ultimately determined that he or she is entitled to be indemnified by the corporation.

(6) A provision made to indemnify directors, members of the corporate body, or officers in any action, suit, or proceeding referred to in subsection (1) or (2), whether contained in the articles of incorporation, the bylaws, a resolution of the directors, an agreement, or otherwise, shall be invalid only insofar as it is in conflict with subsections (1) to (5) and this subsection. Nothing contained in subsections (1) to (5) and this subsection shall affect any rights to indemnification to which persons other than directors and officers may be entitled by contract or otherwise by law. The indemnification provided in subsections (1) to (5) and this subsection continues as to a person who has ceased to be a director, member of the corporate body, officer, employee, or agent, and shall inure to the benefit of the heirs, executors, and administrators of that person.

(7) A health care corporation may purchase and maintain insurance on behalf of any person who is or was a director, officer, employee, or agent of the corporation, or is or was serving at the request of the health care corporation as a director, officer, employee, or agent of another corporation, partnership, joint venture, trust, or other enterprise against any liability asserted against him or her and incurred by him or her in that capacity, or arising out of his or her status as described in this subsection, whether or not the health care corporation would have power to indemnify him or her against this liability under subsections (1) to (6).

(8) For the purposes of subsections (1) to (7), references to a health care corporation include all constituent corporations absorbed in a consolidation or merger and the resulting or surviving corporation, so that a person who is or was a director, officer, employee, or agent of a constituent corporation or is or was serving at the request of such a constituent corporation as a director, officer, employee, or agent of another corporation, partnership, joint

venture, trust, or other enterprise shall stand in the same position under the provisions of this section with respect to the resulting or surviving corporation as he or she would if he or she had served the resulting or surviving corporation in the same capacity.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1214 Rate of interest.

Sec. 214. A health care corporation may by agreement in writing, and not otherwise, agree to pay a rate of interest in excess of the legal rate, and in that case, the defense of usury is prohibited.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1215 Health care corporation as shareholder in other nonprofit corporation; rights, powers, privileges, and liabilities.

Sec. 215. When a health care corporation, consistent with the purposes of the corporation prescribed in this act, is a shareholder in any other nonprofit corporation, its president and other officers or any of its directors may hold the office of director of the other nonprofit corporation the same as if they were individual shareholders in the other nonprofit corporation. The health care corporation, being a shareholder in the other nonprofit corporation, shall possess and exercise all the rights, powers, privileges, and liabilities of individual shareholders.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1216, 550.1217 Repealed. 2002, Act 559, Imd. Eff. Sept. 27, 2002.

Compiler's note: The repealed sections pertained to merger, consolidation, or dissolution of corporation.
Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1218 Health care corporation; prohibited actions.

Sec. 218. A health care corporation shall not do any of the following:

(a) Take any action to change its nonprofit status.

(b) Dissolve, merge, consolidate, mutualize, or take any other action that results in a change in direct or indirect control of the health care corporation or sell, transfer, lease, exchange, option, or convey assets that results in a change in direct or indirect control of the health care corporation.

History: Add. 2002, Act 559, Imd. Eff. Sept. 27, 2002.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1219 Provisions superseded.

Sec. 219. A nonprofit health care corporation is subject to chapter 37 of the insurance code of 1956, 1956 PA 218, MCL 500.3701 to 500.3723. To the extent that a provision of this act concerning health coverage, including, but not limited to, premiums, rates, filings, and coverages, conflicts with chapter 37 of the insurance code of 1956, 1956 PA 218, MCL 500.3701 to 500.3723, chapter 37 of the insurance code of 1956, 1956 PA 218, MCL 500.3701 to 500.3723, supersedes this act.

History: Add. 2003, Act 59, Eff. July 23, 2003.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

PART 3

550.1301 Board of directors; powers and duties generally; appointment, qualifications, and terms of members; vacancy; officer or employee as voting or nonvoting director; method of selection; definitions; prohibition.

Sec. 301. (1) The property and lawful business of a health care corporation existing and authorized to do business under this act shall be held and managed by a board of directors to consist of not more than 35 members. The board shall exercise the powers and authority necessary to carry out the lawful purposes of the corporation, as limited by this act and the articles of incorporation and the bylaws of the corporation.

(2) Four voting members of the board shall be representatives of the public appointed by the governor by and with the advice and consent of the senate. Two of those members shall be retired individuals 62 years of age or older. The term of office of each representative of the public shall be 2 years, and until a successor is appointed and qualified. If a vacancy occurs before the conclusion of a 2-year term, the appointment of a representative to complete the term shall be made in the same manner as the original appointment.

(3) The board of directors shall consist of not more than 25% provider directors. In addition to physician and hospital provider directors, not less than 1 provider director shall be a registered professional nurse who shall be representative of licensees under part 172 of the public health code, Act No. 368 of the Public Acts of 1978, as amended, being sections 333.17201 to 333.17242 of the Michigan Compiled Laws, and not less than 1 provider director shall be representative of the provider whose services, in the 1984 calendar year in the case of an existing health care corporation, or, in the calendar year immediately following incorporation in the case of a newly-formed health care corporation, generated the largest number of benefit claims received by the corporation from its subscribers. Other provider directors shall be as broadly representative of provider classes as possible.

(4) The bylaws of a health care corporation may authorize not more than 1 officer or employee of the corporation to serve as a voting or nonvoting director.

(5) The remaining members of the board of directors shall include representatives of large subscriber groups, medium subscriber groups, small subscriber groups, and nongroup subscribers, in proportions which fairly represent the total subscriber population of the health care corporation. However, at least 3 directors shall represent nongroup subscribers, at least 1 of whom shall be a retired individual 62 years of age or older, and at least 3 directors shall represent small subscriber groups. Large and medium subscriber groups shall be represented, to the greatest extent possible, by an equal number of labor and management representatives and shall be categorized as labor subscriber representatives or management subscriber representatives.

(6) The method of selection of the directors, other than the directors who are representatives of the public, and additional provisions and requirements for further refinement or specification regarding the number of directors comprising each component shall be specified in the bylaws. The terms of office of directors, other than the directors who are representatives of the public, and the method for filling vacancies in those offices shall be provided in the bylaws. However, if a term of office of more than 1 year is prescribed by the bylaws, at least 1/3 of the members of the board shall be selected each year.

(7) The method of selection of each category of subscribers entitled to representation on the board under subsection (5) shall maximize subscriber participation to the extent reasonably practicable. This subsection shall permit, but not require, the statewide election of a director or member of the corporate body. The method of selection shall neither permit nor require nomination, endorsement, approval, or confirmation of a candidate or director by the corporate body, the board of directors, or the management of the health care corporation, or any member or members of any of these. This subsection shall not apply to the selection of an officer or employee as a director pursuant to subsection (4). This subsection shall not limit the rights of any director, member of the corporate body, or employee or officer of the health care corporation to participate in the selection process in his or her capacity as a subscriber, to the same extent as any other subscriber may participate.

(8) For the purposes of this section:

(a) "Health care provider" or "provider" includes:

(*i*) A person defined as a health care provider or provider in section 105(4); a person employed by a health care facility, as defined in section 105(3); or a director, officer, or trustee of a health care provider, as defined in section 105(4), unless the person serves in that capacity as a representative selected by the same subscriber group or collective bargaining representative which the person represents on the board of a health care corporation.

(*ii*) Except as provided in subdivision (b), a spouse, child, or parent of a health care provider who resides in the same household.

(*iii*) A person who receives more than 25% of his or her annual income through the provision of goods or services to health care providers, or who is an employee, officer, trustee, or director of a firm or organization which receives more than 25% of its annual income through the provision of goods or services to health care providers.

(b) For purposes of determining whether a director is a provider director, "health care provider" or "provider" does not include a spouse, child, or parent of a health care provider who resides in the same household if all of the following criteria are met:

(*i*) Not more than 1/3 of the total annual household income is earned by that health care provider.

(*ii*) The term of office of the director commences in the 1988 calendar year.

(*iii*) Not more than 2 directors qualify for the exemption under this subdivision.

(9) A director shall not be an employee, agent, officer, or director of an insurance company writing disability insurance inside or outside this state.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1988, Act 45, Imd. Eff. Mar. 11, 1988.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1302 Bylaws generally.

Sec. 302. (1) The board of directors shall adopt initial bylaws and may amend or repeal those bylaws or adopt new bylaws, subject to the prior approval or certification by the attorney general. The bylaws may contain any provision for the regulation and management of the affairs of the health care corporation not inconsistent with the articles of incorporation, this act, or any other applicable provision of law.

(2) The initial bylaws, and any new bylaws, amendments, or repealers shall be submitted to the attorney general for review and approval. The attorney general shall approve the initial bylaws, new bylaws, amendments, or repealers if the attorney general determines that they comply with this act.

(3) If the attorney general disapproves all or any part of the initial bylaws, new bylaws, amendments, or repealers, he or she shall return them to the board with a written statement setting forth the reasons for the disapproval and any recommendations for change which he or she may wish to suggest, not later than 30 days following their receipt. Bylaws, amendments, and repealers not returned to the health care corporation within this 30-day period shall be considered to comply with this act and shall be considered approved.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1303 Meetings; required provisions in bylaws; notice; waiver; participation by conference telephone or similar communications equipment; quorum; action by board; actions requiring majority vote; record roll call vote; recording vote in minutes.

Sec. 303. (1) Regular or special meetings of the board or a committee of the board shall be held within this state. With respect to regular or special meetings of the board or a committee of the board, the bylaws shall include provisions regarding all of the following:

(a) The minimum number of regular meetings to be held each year.

(b) The publication and advance distribution of an agenda, including provisions respecting the time and place of the meeting and the business to be conducted.

(c) Voting procedures. The use of proxies and round robins shall not be allowed.

(2) Notice of a regular meeting shall be given at least 15 days before the meeting and notice of a special meeting shall be given at least 24 hours before the meeting. Attendance of a director at a meeting constitutes a waiver of notice of the meeting, except in cases in which a director attends a meeting for the express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened.

(3) Unless otherwise restricted by the articles of incorporation or bylaws, a member of the board or of a committee designated by the board may participate in a meeting by means of conference telephone or similar communications equipment by means of which all individuals participating in the meeting can hear each other. Participation in a meeting pursuant to this subsection constitutes presence in person at the meeting.

(4) A majority of the members of the board then in office, or of the members of a committee thereof, constitutes a quorum for the transaction of business, unless the articles or bylaws provide for a larger number. The vote of the majority of members present at a meeting at which a quorum is present constitutes the action of the board or of the committee, unless the vote of a larger number is required by this act, the articles, or the bylaws. The following actions shall require the vote of not less than a majority of the members of the board then in office:

(a) Adoption of bylaws, amendments to bylaws, or repealers of bylaws.

(b) Adoption of articles of incorporation, amendments to articles, or repealers of articles.

(c) The proposal or establishment of rates or rating systems; the adoption of provider class plans or provider contracts; or the adoption of compensation for officers of the corporation.

(5) The bylaws shall provide that a record roll call vote shall be taken at the request of any 5 board members. The vote of each member shall be recorded in the minutes.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1304 Books, records, and minutes; copy of minutes; disclosure, publication, and dissemination of minutes; compelling production of books or records.

Sec. 304. (1) A health care corporation shall keep accurate books and records of account and minutes of the proceedings of the board of directors of the health care corporation, committees of the board, and the corporate body. The books, records, and minutes may be in written form or in any other form capable of being converted into written form within a reasonable time. One copy of the minutes or draft minutes from each meeting of the board of directors shall be transmitted to the commissioner within 15 days after the meeting was held. Upon the request of a member of the board of directors, consistent with the board member's fiduciary duty under section 310, a subscriber shall receive, within 15 days after receipt of the request, a copy of the minutes or draft minutes of 1 or more meetings of the board, its committee, or the corporate body, and may be charged not more than the reasonable cost of copying and postage.

(2) Minutes shall be kept and need not be disclosed, except to the commissioner as provided in section 603, for those portions of meetings which are held for the following purposes:

(a) To consider the hiring, promotion, dismissal, suspension, or discipline of an employee.

(b) To consider the purchase, lease, or sale of real property.

(c) For strategy and negotiation sessions connected with the negotiations of a collective bargaining agreement when either party requests a closed meeting.

(d) For trial or settlement strategy sessions in connection with specific contemplated or pending litigation. If these sessions are with respect to litigation to which the commissioner or the attorney general is a party, minutes regarding these sessions shall not be subject to examination and free access under section 603.

(e) To consider medical records of an individual.

(f) To consider the acquisition or disposal of certificates of stock, bonds, certificates of indebtedness, and other intangibles in which the corporation may invest funds under section 206, if the information regarding proposed acquisition or disposal may affect the price paid or received.

(g) To consider provider appeals when the provider has requested a closed hearing.

(h) To discuss marketing strategy with regard to a particular customer or limited group of customers, or to discuss a new or changed benefit, the premature disclosure of which would have an adverse impact on the health care corporation.

(i) To consider the removal of a director from the board when the director requests a closed hearing.

(3) The date and time of preparation and existence of the minutes described in subsection (2), the contents of which shall not be disclosable except to the commissioner as provided in section 603, shall be noted in the minutes required to be kept under subsection (1). Once action is taken by the board to implement a consideration or discussion described in subsection (2)(b), (f), (g), or (h), once a collective bargaining agreement is reached as described in subsection (2)(c), once litigation is no longer pending as described in subsection (2)(d), or once a closed hearing is concluded as described in subsection (2)(i), and upon the request of the director to whom the hearing pertained, the minutes relating to the consideration, discussion, or strategy session shall be published and disseminated with the next succeeding set of minutes published and disseminated under subsection (1), and may be disclosed by the commissioner to other persons under section 603(3).

(4) The circuit court, upon proof of a proper purpose, may compel the production of books and records for examination by a subscriber or the attorney general.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1305 Establishment and composition of corporate body; service of members on committees; membership on board of directors.

Sec. 305. (1) A health care corporation may establish a corporate body. The corporate body shall consist of individuals selected in the same manner as individuals are selected to serve as nonpublic members on the board of directors. The size of the corporate body shall be such that, for each nonpublic voting director on the board of directors of the corporation, there are 2 members of the corporate body. The 4 public members selected pursuant to section 301(2) shall be considered to be members of the corporate body as well as members of the board of

directors. An additional 4 public members shall be appointed to the corporate body by the governor by and with the advice and consent of the senate, 2 of whom shall be retired individuals 62 years of age or older.

(2) Members of the corporate body may serve on committees of the board of directors. A member of the corporate body may be selected for membership on the board of directors, provided that the selection is made in accordance with the provisions of this part governing the selection of voting directors of the board.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1306 Effect of common directorship, officership, or interest on validity of contract or other transaction; burden of establishing validity of contract; exclusion of common or interested directors in determination of quorum; compensation of directors; bylaws regarding conflict of interest.

Sec. 306. (1) A contract or other transaction between a health care corporation and 1 or more of its directors or officers, or between a health care corporation and any other corporation, firm, or association of any type or kind in which 1 or more of its directors or officers are directors or officers, or are otherwise interested, is not void or voidable solely because of such common directorship, officership, or interest, or solely because the directors are present at the meeting of the board or committee thereof which authorizes or approves the contract or transaction, if all of the following conditions are satisfied:

(a) The contract or other transaction is fair and reasonable to the corporation when it is authorized, approved, or ratified.

(b) The material facts as to the officer's or director's relationship or interest and as to the contract or transaction are disclosed or known to the board or committee, and the board or committee authorizes, approves, or ratifies the contract or transaction by a vote sufficient for the purpose. The conditions of this subdivision shall be considered satisfied only if the officer or director has announced the potential conflict prior to the vote, the minutes of the meeting reflect that announcement, and the officer or director abstained from the vote.

(2) When the validity of a contract described in subsection (1) is questioned, the burden of establishing its validity on the grounds prescribed is upon the director, officer, corporation, firm, or association asserting its validity.

(3) Common or interested directors shall not be counted in determining the presence of a quorum at a board or committee meeting at the time a contract or transaction described in subsection (1) is authorized, approved, or ratified.

(4) The board, by affirmative vote of a majority of directors in office and irrespective of any personal interest of any of them, may establish reasonable compensation of directors for services to the health care corporation as directors or officers of the health care corporation.

(5) The bylaws of a health care corporation may include provisions regarding conflict of interest which are more stringent than this section.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1307 Advisory councils; committees of board of directors; bylaws regarding membership and emergency meetings and actions.

Sec. 307. The board of directors may establish those advisory councils and, unless otherwise provided in the articles of incorporation or bylaws, those committees it considers necessary to perform its duties. Members of the corporate body may serve on committees of the board of directors. With respect to committees of the board, the bylaws shall include provisions regarding all of the following:

(a) Provisions which assure that the membership of each committee provides for representation of all of the components of directors, as defined in the bylaws, to the greatest extent practicable.

(b) Provisions regarding emergency meetings of the executive committee of the health care corporation, and action by that committee on behalf of the board in cases of emergency, as defined by the bylaws.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1308 Committees of board of directors; powers and authority; prohibited activities;

emergency actions.

Sec. 308. (1) To the extent provided by resolution of the board or in the bylaws or articles, a committee established pursuant to section 307 may exercise the powers and authority of the board in management of the business and affairs of the health care corporation. The board shall review and may modify subject to the rights of third parties any action or decision of a committee. A committee shall not do any of the following:

(a) Amend the articles of incorporation.

(b) Adopt an agreement of merger or consolidation.

(c) Authorize the sale, lease, or exchange of all or substantially all of the corporation's property and assets.

(d) Approve, adopt, or amend provider contracts, provider class plans, rates charged to subscribers, or a certificate.

(e) Amend the bylaws of the corporation.

(f) Fill vacancies on the board.

(g) Fix compensation of the directors or officers.

(h) Perform other similar acts of a final or binding nature with respect to the business of the corporation.

(2) This section shall not prohibit emergency actions by the executive committee on behalf of the board, as authorized in the bylaws of the health care corporation.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1309 Officers and assistants; selection; restriction; authority and duties; removal; contractual rights; bond; vacancies; compensation; pension.

Sec. 309. (1) The board of directors shall select the officers of the health care corporation and a chairperson, vice-chairperson, and other board officers and assistants as the board considers necessary. However, an officer shall not execute, acknowledge, or verify an instrument in more than 1 capacity. Officers shall have only the authority, and assistants shall perform only those duties, in the management of the property and affairs of the corporation, as is provided in the bylaws or delegated to the officers and assistants by the board of directors, consistent with the bylaws. An officer or assistant may be removed by the board of directors with or without cause, subject to the contract rights, if any, of the officer or assistant. The selection of an officer or assistant does not of itself create contract rights. The board of directors may secure the fidelity of any or all of the officers by bond or otherwise. Unless otherwise provided in the articles or bylaws, the board of directors may fill vacancies in an office described in this subsection which occur for any reason.

(2) A health care corporation shall not pay a salary, compensation, or emolument to a director or officer unless the payment is first authorized by the board of directors of the corporation. A director, officer, assistant, or employee shall not be compensated unreasonably.

(3) A health care corporation shall not grant a pension to an officer or director, or to a member of the family of an officer or director after the death of the officer or director. However, the corporation, pursuant to the terms of a retirement plan adopted by the board of directors of the corporation and approved by the commissioner, may provide for any person who is or has been a salaried employee or officer of the corporation, a pension payable upon retirement, as provided in the approved retirement plan, and life insurance benefits payable at death.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1310 Fiduciary duties; scope and manner of discharge; removal of director for breach of fiduciary duty; notice and hearing.

Sec. 310. (1) With respect to management of the affairs and property of the health care corporations, and in the selection, supervision, and control of committees of the board, employees of the health care corporation, and officers, each director and officer, and the composite board, shall exercise the duties of a fiduciary toward the health care corporation and the subscribers of the health care corporation as a whole, and shall discharge his or her duties with the degree of diligence, care, and skill which an ordinarily prudent person would exercise under the same or similar circumstances in a like position. In discharging his or her duties, a director or officer, when acting in good faith, may rely upon the opinion of counsel for the corporation, upon the report of an independent appraiser selected with reasonable care by the board, or upon financial statements of the corporation represented to the director or officer to be correct by the president or the officer of the corporation having charge of its books of account, or

stated in a written report by an independent public or certified public accountant or firm of such accountants fairly to reflect the financial condition of the corporation.

(2) After notice and a hearing before the board, a director may be removed from the board by a vote of 2/3 of the directors selected and serving on the board for a breach of fiduciary duty.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1311 Liability for misapplication or misuse of corporate money or property.

Sec. 311. Each director or officer of a health care corporation shall be individually liable for the misapplication or misuse of corporate money or property caused through the neglect or failure of that director or officer to discharge his or her duties in compliance with the standards prescribed in section 310, or through wilful violation of this act or other laws governing the health care corporation.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1312 Action for failure to perform duties; commencement.

Sec. 312. An action against a director or officer for failure to perform the duties imposed by this act shall be commenced within 3 years after the cause of action has accrued, or within 2 years after the time when the cause of action is discovered, or should reasonably have been discovered, by a person complaining of the failure to perform, whichever occurs sooner.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1313 False statement as misdemeanor; liability for false statement or report; commencement of action for civil liability.

Sec. 313. (1) Except with respect to statements which are subject to prosecution for perjury, as defined in section 423 of Act No. 328 of the Public Acts of 1931, being section 750.423 of the Michigan Compiled Laws, a person, or an agent, director, or officer of a health care corporation, who knowingly makes any false oral or written statement as to a material fact, in or with respect to a report required by this act, or in the course of a hearing or examination held pursuant to this act, is guilty of a misdemeanor. In addition, the person, agent, director, or officer knowingly making the false statement and each person, agent, director, or officer knowingly authorizing, signing, or making the false report shall be jointly and severally personally liable to any person who has become a creditor of the health care corporation upon the faith of the false statement or the false report.

(2) An action for the civil liability imposed by this section shall be commenced within 2 years after discovery of the false statement or within 6 years after the report has been made by the person, agent, director, or officer of the health care corporation, whichever is sooner.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

PART 4

550.1401 Offering of health care benefits; limiting benefits; division of benefits into classes or kinds; prohibited conduct; grounds for denial of coverage; coordination of benefits, subrogation, and nonduplication of benefits; health care corporation as party in interest; limiting or denying coverage or participation status; requirements for participation and reimbursement; determination by commissioner; definitions.

Sec. 401. (1) A health care corporation established, maintained, or operating in this state shall offer health care benefits to all residents of this state, and may offer other health care benefits as the corporation specifies with the approval of the commissioner.

(2) A health care corporation may limit the health care benefits that it will furnish, except as provided in this act,

and may divide the health care benefits that it elects to furnish into classes or kinds.

(3) A health care corporation shall not do any of the following:

(a) Refuse to issue or continue a certificate to 1 or more residents of this state, except while the individual, based on a transaction or occurrence involving a health care corporation, is serving a sentence arising out of a charge of fraud, is satisfying a civil judgment, or is making restitution pursuant to a voluntary payment agreement between the corporation and the individual.

(b) Refuse to continue in effect a certificate with 1 or more residents of this state, other than for failure to pay amounts due for a certificate, except as allowed for refusal to issue a certificate under subdivision (a).

(c) Limit the coverage available under a certificate, without the prior approval of the commissioner, unless the limitation is as a result of: an agreement with the person paying for the coverage; an agreement with the individual designated by the persons paying for or contracting for the coverage; or a collective bargaining agreement.

(d) Rate, cancel benefits on, refuse to provide benefits for, or refuse to issue or continue a certificate solely because a subscriber or applicant is or has been a victim of domestic violence. A health care corporation shall not be held civilly liable for any cause of action that may result from compliance with this subdivision. This subdivision applies to all health care corporation certificates issued or renewed on or after June 1, 1998. As used in this subdivision, "domestic violence" means inflicting bodily injury, causing serious emotional injury or psychological trauma, or placing in fear of imminent physical harm by threat or force a person who is a spouse or former spouse of, has or has had a dating relationship with, resides or has resided with, or has a child in common with the person committing the violence.

(e) Require a member or his or her dependent or an applicant for coverage or his or her dependent to do either of the following:

(*i*) Undergo genetic testing before issuing, renewing, or continuing a health care corporation certificate.

(*ii*) Disclose whether genetic testing has been conducted or the results of genetic testing or genetic information.

(4) Subsection (3) does not prevent a health care corporation from denying to a resident of this state coverage under a certificate for any of the following grounds:

(a) That the individual was not a member of a group that had contracted for coverage under this certificate.

(b) That the individual is not a member of a group with a size greater than a minimum size established for a certificate pursuant to sound underwriting requirements.

(c) That the individual does not meet requirements for coverage contained in a certificate.

(d) For groups of under 100 subscribers and except as otherwise provided in section 3709 of the insurance code of 1956, 1956 PA 218, MCL 500.3709, that the group that the individual is a member of has failed to enroll enough of its eligible members with the health care corporation. A denial under this subdivision shall be made only if the health care corporation determines that the cost for the portion of the group applying for coverage would be at least 50% more on a per subscriber basis than the per subscriber cost for the whole group. A denial under this subdivision shall not be based on the health status of any individual in the group or his or her dependent. A denial under this subdivision shall be based on sound actuarial principles and may be based on 1 or more of the following:

(*i*) That the contract holder for the group applying for coverage is also offering a self-funded health benefit plan.

(*ii*) That the group applying for coverage is composed entirely of the contract holder's retiree business segment.

(*iii*) That the average individual age of the members of the group applying for coverage is either 50% higher or 10 years higher than the average individual age for the whole group.

(5) A certificate may provide for the coordination of benefits, subrogation, and the nonduplication of benefits. Savings realized by the coordination of benefits, subrogation, and nonduplication of benefits shall be reflected in the rates for those certificates. If a group certificate issued by the corporation contains a coordination of benefits provision, the benefits shall be payable pursuant to the coordination of benefits act, 1984 PA 64, MCL 550.251 to 550.255.

(6) A health care corporation shall have the right to status as a party in interest, whether by intervention or otherwise, in any judicial, quasi-judicial, or administrative agency proceeding in this state for the purpose of enforcing any rights it may have for reimbursement of payments made or advanced for health care services on behalf of 1 or more of its subscribers or members.

(7) A health care corporation shall not directly reimburse a provider in this state who has not entered into a participating contract with the corporation.

(8) A health care corporation shall not limit or deny coverage to a subscriber or limit or deny reimbursement to a provider on the ground that services were rendered while the subscriber was in a health care facility operated by this state or a political subdivision of this state. A health care corporation shall not limit or deny participation status to a health care facility on the ground that the health care facility is operated by this state or a political subdivision of

this state, if the facility meets the standards set by the corporation for all other facilities of that type, government-operated or otherwise. To qualify for participation and reimbursement, a facility shall, at a minimum, meet all of the following requirements, which shall apply to all similar facilities:

(a) Be accredited by the joint commission on accreditation of hospitals.

(b) Meet the certification standards of the medicare program and the medicaid program.

(c) Meet all statutory requirements for certificate of need.

(d) Follow generally accepted accounting principles and practices.

(e) Have a community advisory board.

(f) Have a program of utilization and peer review to assure that patient care is appropriate and at an acute level.

(g) Designate that portion of the facility that is to be used for acute care.

(9) Not later than the close of business on the seventh business day after denying coverage under subsection (4)(d), the health care corporation shall notify the commissioner of this denial and shall supply the commissioner with the information used in determining the denial. The commissioner shall determine whether he or she will approve or disapprove the health care corporation denial not later than the close of business on the seventh business day after receipt of the notice and shall promptly notify the health care corporation of his or her determination. The commissioner shall base his or her determination under this subsection on whether the health care corporation met the standards in subsection (4)(d). The health care corporation or the denied contract holder may appeal the commissioner's decision in circuit court. The commissioner shall report to the senate and house of representatives standing committees on insurance issues by May 15, 2005 and biennially thereafter all of the following:

(a) The number of denials made each calendar year by a health care corporation under subsection (4)(d).

(b) The number of denials under subdivision (a) that were approved by the commissioner under this subsection and a summary of the type of group approved.

(c) The number of denials under subdivision (a) that were disapproved by the commissioner under this subsection and a summary of the type of group disapproved.

(d) The number of decisions by the commissioner under this subsection that have been appealed and the results of the appeals.

(10) As used in this section:

(a) "Clinical purposes" includes all of the following:

(*i*) Predicted risk of diseases.

(*ii*) Identifying carriers for single-gene disorders.

(*iii*) Establishing prenatal and clinical diagnosis or prognosis.

(*iv*) Prenatal, newborn, and other carrier screening, as well as testing in high-risk families.

(*v*) Tests for metabolites if undertaken with high probability that an excess or deficiency of the metabolite indicates or suggests the presence of heritable mutations in single genes.

(*vi*) Other tests if their intended purpose is diagnosis of a presymptomatic genetic condition.

(b) "Genetic information" means information about a gene, gene product, or inherited characteristic derived from a genetic test.

(c) "Genetic test" means the analysis of human DNA, RNA, chromosomes, and those proteins and metabolites used to detect heritable or somatic disease-related genotypes or karyotypes for clinical purposes. A genetic test must be generally accepted in the scientific and medical communities as being specifically determinative for the presence, absence, or mutation of a gene or chromosome in order to qualify under this definition. Genetic test does not include a routine physical examination or a routine analysis, including, but not limited to, a chemical analysis, of body fluids, unless conducted specifically to determine the presence, absence, or mutation of a gene or chromosome.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1984, Act 66, Imd. Eff. Apr. 18, 1984;—Am. 1998, Act 135, Imd. Eff. June 24, 1998;—Am. 2000, Act 26, Imd. Eff. Mar. 15, 2000;—Am. 2003, Act 59, Eff. July 23, 2003.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1401a Health care service rendered by dentist; benefits or reimbursement; "dentist" defined; certificates to which section applicable.

Sec. 401a. (1) If a group or nongroup certificate of a health care corporation provides for health care benefits for a health care service, those benefits or reimbursement for the provision of the service shall not be denied because the service was rendered by a dentist, provided the service was legally performed.

(2) As used in this section, "dentist" means an individual licensed under part 166 of Act No. 368 of the Public

Acts of 1978, being sections 333.16601 to 333.16647 of the Michigan Compiled Laws.

(3) This section shall apply only with respect to certificates which are issued or renewed on or after the effective date of this section, and shall apply notwithstanding any certificate provision to the contrary.

History: Add. 1982, Act 290, Imd. Eff. Oct. 7, 1982.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1401b Certificate providing benefits for mental health services; requirements.

Sec. 401b. A certificate issued by a corporation which provides benefits for mental health services shall provide benefits for mental health services provided to an individual by a mental health care provider operated by or under contract with the department of mental health or a county community mental health board in those instances when appropriate mental health services cannot be delivered otherwise, or if the provider of the mental health services is designated by an order of a court; provided that the mental health provider meets the standards set by the corporation for all other providers of the type.

History: Add. 1984, Act 230, Eff. Dec. 20, 1984.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1401c Replacement group certificate with preexisting condition limitation; elimination, reduction, or limitation of benefits; "disability coverage" defined.

Sec. 401c. (1) If existing group disability coverage is replaced by a group certificate with a preexisting condition limitation and insuring 10 or more members, coverage in the replacement certificate applicable to the preexisting condition limitation for an individual who had been covered for that condition by the replaced coverage shall be not less than the lesser of the following:

(a) The coverage of the replacement certificate without application of the preexisting condition limitation.

(b) The benefits of the replaced group disability coverage until the individual's preexisting condition limitation expires under the replacement certificate.

(2) Other than as provided in subsection (1), a replacement group certificate insuring 10 or more members shall not include a limitation upon an individual or exclude an individual who was covered by the group disability coverage being replaced if the individual is a member of the class or classes of individuals eligible for coverage under the replacement certificate.

(3) If existing group disability coverage issued or renewed on or after January 1, 1992 is replaced by a group certificate with a preexisting condition limitation and insuring less than 10 members, the replaced coverage shall extend benefits for the condition excluded by the replacement certificate because of the application of a preexisting condition limitation by providing benefits for that condition until the term of the preexisting condition limitation has expired or 6 months have elapsed, whichever occurs first. An individual not covered for a condition under replaced group disability coverage because the term of a preexisting condition limitation has not expired is covered for that condition under the replaced coverage pursuant to this subsection when the term of the preexisting condition limitation in the replaced coverage expires. If there is a dispute between the replacement carrier and the replaced carrier as to whether an individual's condition is included within a preexisting condition limitation, benefits shall be paid by the replacement carrier pending resolution of the dispute. This subsection applies only to the extent that benefits would have been available for the preexisting condition under the replaced coverage. This subsection applies only if the replaced master coverage has been in effect for at least 6 months.

(4) If existing group disability coverage issued or renewed on or after January 1, 1992 is replaced by a group certificate with a preexisting condition limitation and insuring less than 10 members, the replacement certificate shall not include a limitation for a period exceeding 6 months upon an individual or exclude an individual who was covered by the group disability coverage being replaced if the individual is a member of the class or classes of individuals eligible for coverage under the replacement certificate.

(5) This section does not preclude an elimination, reduction, or limitation of benefits which applies to an entire plan. This section applies to individuals who are covered under the replaced certificate at the time of replacement and does not apply to individuals who become eligible for or apply for coverage under a replacement group certificate after that replacement certificate is issued.

(6) As used in this section, "disability coverage" means expense-incurred hospital, medical, or surgical coverage.

History: Add. 1989, Act 256, Eff. Jan. 1, 1992.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1401d Services performed by physician's assistant; reimbursement; conditions; applicability of section; supervision by physician; definitions.

Sec. 401d. (1) Subject to subsections (2) and (3), if a health care corporation group or nongroup certificate provides for health care benefits for services performed by a physician's assistant, those benefits or reimbursement for those benefits at the prevailing rate shall not be denied if the services were performed by a physician's assistant acting within the scope of his or her license and provided that the following are met:

(a) If the services were performed by a physician's assistant working for a physician or facility specializing in a particular area of medicine, a physician that specializes in that area of medicine was physically present on the premises when the physician's assistant performed the services.

(b) If the services were performed by a physician's assistant working for a physician or facility engaging in general family practice, a physician need not have been physically present on the premises when the physician's assistant performed the services so long as a consulting physician is within 150 miles or 3 hours' commute to where the services are performed.

(2) This section applies to a physician's assistant who performs services in any of the following:

(a) A county with a population of 25,000 or less.

(b) A certified rural health clinic.

(c) A health professional shortage area.

(3) For purposes of subsection (1), a physician supervising a physician's assistant shall do so from within Michigan or from a state bordering Michigan.

(4) As used in this section:

(a) "Health professional shortage area" means that term as defined in section 332(a)(1) of subpart II of part C of title III of the public health service act, chapter 373, 90 Stat. 2270, 42 U.S.C. 254e.

(b) "Medicaid" means the program of medical assistance established under title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396g and 1396i to 1396u.

(c) "Medicare" means the federal medicare program established under title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395 to 1395b, 1395b-2, 1395c to 1395i, 1395i-2 to 1395i-4, 1395j to 1395t, 1395u to 1395w-2, 1395w-4 to 1395zz, and 1395bbb to 1395ccc.

(d) "Physician's assistant" means an individual licensed as a physician's assistant under article 15 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.16101 to 333.18838 of the Michigan Compiled Laws.

(e) "Rural health clinic" means a rural health clinic as defined under section 1861 of part C of title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395x, and certified to participate in medicaid and medicare.

History: Add. 1991, Act 102, Imd. Eff. Sept. 6, 1991;—Am. 1993, Act 258, Imd. Eff. Nov. 29, 1993.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1401e Group certificate issued by health care corporation; renewal or continuation; guaranteed renewal.

Sec. 401e. (1) Except as provided in this section, a health care corporation that has issued a nongroup certificate shall renew or continue in force the certificate at the option of the individual.

(2) Except as provided in this section, a health care corporation that has issued a group certificate shall renew or continue in force the certificate at the option of the sponsor of the plan.

(3) Guaranteed renewal is not required in cases of fraud, intentional misrepresentation of material fact, lack of payment, if the health care corporation no longer offers that particular type of coverage in the market, or if the individual or group moves outside the service area.

History: Add. 1996, Act 516, Eff. Oct. 1, 1997.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1401f Health care corporation; access to obstetrician-gynecologist.

Sec. 401f. (1) A health care corporation certificate that requires a member to designate a participating primary care provider and provides for annual well-woman examinations and routine obstetrical and gynecologic services

shall permit a female member to access an obstetrician-gynecologist for annual well-woman examinations and routine obstetrical and gynecologic services.

(2) A health care corporation shall not require prior authorization or referral for access under subsection (1) to an obstetrician-gynecologist who participates with the health care corporation. A health care corporation may require prior authorization or referral for access to a nonparticipating obstetrician-gynecologist.

(3) A description of the benefit provided by this section shall be included by the health care corporation in a communication sent to the individual or group purchaser of coverage.

History: Add. 1998, Act 412, Eff. Mar. 23, 1999.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1401g Health care corporation; access to pediatric care services.

Sec. 401g. (1) A health care corporation certificate that requires a member to designate a participating primary care provider and provides for dependent care coverage shall permit a dependent minor member to select and access a pediatrician for general pediatric care services.

(2) A health care corporation shall not require prior authorization or referral for access under subsection (1) to a pediatrician who participates with the health care corporation. A health care corporation may require prior authorization or referral for access to a nonparticipating pediatrician.

History: Add. 1999, Act 178, Imd. Eff. Nov. 16, 1999.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1401h Health care corporation providing prescription drug coverage; formulary restrictions.

Sec. 401h. A health care corporation that provides coverage for prescription drugs and limits those benefits to drugs included in a formulary shall do all of the following:

(a) Provide for participation of participating physicians, dentists, and pharmacists in the development of the formulary.

(b) Disclose to health care providers and upon request to members the nature of the formulary restrictions.

(c) Provide for exceptions from the formulary limitation when a nonformulary alternative is a medically necessary and appropriate alternative. This subdivision does not prevent a health care corporation from establishing prior authorization requirements or another process for consideration of coverage or higher cost-sharing for nonformulary alternatives. Notice as to whether or not an exception under this subdivision has been granted shall be given by the health care corporation within 24 hours after receiving all information necessary to determine whether the exception should be granted.

History: Add. 1999, Act 175, Imd. Eff. Nov. 16, 1999.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1401i Prescription drug coverage; pilot project; provisions; interim report; determination; evaluation.

Sec. 401i. (1) Beginning January 1, 2004, a health care corporation shall establish and offer to provide or include prescription drug coverage in at least 1 nongroup certificate and at least 1 group conversion certificate as a pilot project under this section. This pilot project shall continue through December 1, 2006 and, while in pilot project status, is not subject to the guaranteed renewability provisions of section 401e.

(2) Unless an order of adjustment issued under subsection (4)(b)(*ii*) provides otherwise, a certificate that includes prescription drug coverage under subsection (1) shall include all of the following:

(a) At a minimum, a prescription drug benefit that includes a co-pay of no more than 50% of the health care corporation's approved amount for the payment of prescription drugs, with a minimum co-pay of $10.00 and a maximum co-pay of $100.00 per prescription.

(b) An annual per person benefit maximum of no less than $2,500.00.

(c) A provision that members will be entitled to purchase prescription drugs at a discount under the affinity program offered by the health care corporation once their annual per person prescription drug benefit maximum has been reached.

(3) Not later than July 1, 2005, the health care corporation shall issue an interim report to the commissioner regarding the claims experience of the market segment under this section and the ongoing viability of the pilot project. Not later than July 1, 2006, the health care corporation shall issue a final report to the commissioner

regarding the claims experience of the market segment under this section and the ongoing viability of the pilot project.

(4) By December 1, 2006, the commissioner shall determine if the nongroup and group conversion certificates providing the prescription drug benefit under this section provide a useful benefit to its subscribers in an actuarially sound manner. Based upon this determination, the commissioner shall do 1 of the following:

(a) If the commissioner determines that a certificate does provide a useful benefit to its subscribers in an actuarially sound manner, the commissioner shall order the termination of the pilot project designation and order that the program continue indefinitely. If the pilot project is discontinued and the program is continued indefinitely beyond the date prescribed in subsection (3) or (5), then the certificate is subject to the guaranteed renewability provisions of section 401e.

(b) If the commissioner determines that a certificate does not provide a useful benefit to its subscribers in an actuarially sound manner, the commissioner shall do 1 of the following:

(*i*) Order the termination of the pilot project under this section and terminate the offering of prescription drug coverage in the nongroup and group conversion certificates.

(*ii*) Order an adjustment of the pilot project to operate in an actuarially sound manner and order that the pilot project continue for a specified time period. An order of adjustment under this subparagraph may revise the requirements of subsection (2) regarding coverage required under the certificates.

(5) If the commissioner orders an adjustment of the pilot project under subsection (4), the commissioner shall evaluate the project after 2 years of operation and make a determination in the same manner as prescribed in subsection (4).

History: Add. 2003, Act 41, Eff. July 15, 2003.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1401j Prescription drug coverage; rate differentials; filing.

Sec. 401j. The rates charged to nongroup and group conversion subscribers for a certificate that includes prescription drug coverage pursuant to section 401i may include rate differentials based on age, with not more than 8 separate age bands. The health care corporation shall file its rates for the prescription drug coverage in this section in the same manner and under the same requirements as provided in section 607.

History: Add. 2003, Act 59, Eff. July 23, 2003.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1402 Health care corporation; prohibited conduct; commission or compensation; new preexisting condition limitation waiting period; readjusting rates; participation in trade practice conference for disability insurers; provider class plan not altered or superseded; probable cause to believe provisions violated; notice; disposition of matter by agreement of parties; action for damages; hearing; issuance of cease and desist order; violation of cease and desist order; civil fine; action for actual monetary damage; attorneys' fees.

Sec. 402. (1) A health care corporation shall not do any of the following:

(a) Misrepresent pertinent facts or certificate provisions relating to coverage.

(b) Fail to acknowledge promptly or to act reasonably and promptly upon communications with respect to a claim arising under a certificate.

(c) Fail to adopt and implement reasonable standards for the prompt investigation of a claim arising under a certificate.

(d) Refuse to pay claims without conducting a reasonable investigation based upon the available information.

(e) Fail to affirm or deny coverage of a claim within a reasonable time after a claim has been received.

(f) Fail to attempt in good faith to make a prompt, fair, and equitable settlement of a claim for which liability has become reasonably clear.

(g) Compel members to institute litigation to recover amounts due under a certificate by offering substantially less than the amounts due.

(h) By making reference to written or printed advertising material accompanying or made part of an application for coverage, attempt to settle a claim for less than the amount which a reasonable person would believe was due under the certificate.

(i) For the purpose of compelling a member to accept a settlement or compromise in a claim, make known to the

member a policy of appealing from administrative hearing decisions in favor of members.

(j) Attempt to settle a claim on the basis of an application which was altered without notice to, or knowledge or consent of, the subscriber under whose certificate the claim is being made.

(k) Delay the investigation or payment of a claim by requiring a member, or the provider of health care services to the member, to submit a preliminary claim and then requiring subsequent submission of a formal claim, seeking solely the duplication of a verification.

(*l*) Fail to promptly provide a reasonable explanation of the basis for denial of a claim or for the offer of a compromise settlement.

(m) Fail to promptly settle a claim where liability has become reasonably clear under 1 portion of a certificate in order to influence a settlement under another portion of the certificate.

(2) In order to induce a person to contract or to continue to contract with the health care corporation for the provision of health care benefits or administrative or other services offered by the corporation; to induce a person to lapse, forfeit, or surrender a certificate issued by the health care corporation; or to induce a person to secure or terminate coverage with another health care corporation, insurer, health maintenance organization, or other person, a health care corporation shall not, directly or indirectly:

(a) Issue or deliver to the person money or any other valuable consideration.

(b) Offer to make or make an agreement relating to a certificate other than as plainly expressed in the certificate.

(c) Offer to give or pay, or give or pay, directly or indirectly, a rebate or part of the premium, or an advantage with respect to the furnishing of health care benefits or administrative or other services offered by the corporation except as reflected in the rate and expressly provided in the certificate.

(d) Make, issue, or circulate, or cause to be made, issued, or circulated, any estimate, illustration, circular, or statement misrepresenting the terms of a certificate or contract for administrative or other services, the benefits thereunder, or the true nature thereof.

(e) Make a misrepresentation or incomplete comparison, whether oral or written, between certificates of the corporation or between certificates or contracts of the corporation and another health care corporation, health maintenance organization, or other person.

(3) A health care corporation shall not provide a commission or other compensation to the health care corporation's agent or employee for the sale or service of a health care benefits certificate issued to an individual eligible for medicare, unless the amount of the commission or compensation paid in the first year of the certificate is not more than the amount of the commission or compensation that the health care corporation's agent or employee receives for the certificate in each of the 2 subsequent, consecutive annual renewal periods.

(4) A health care corporation shall not issue a certificate to an individual eligible for medicare that provides for a new preexisting condition limitation waiting period if coverage is converted to or replaced by a new or other form of similar coverage with the same health care corporation or any of the health care corporation's affiliates. If the preexisting condition limitation waiting period in the original or replaced certificate has not expired, the replacing certificate may include the remaining term of the preexisting condition limitation waiting period of the replaced certificate. This subsection does not apply to an increase in benefits voluntarily selected by the individual.

(5) Nothing in subsection (2) shall prevent a health care corporation from readjusting the rates charged to a subscriber group which is experience-rated based on the previous claims of the group.

(6) The commissioner shall allow a health care corporation to participate in any trade practice conference for disability insurers convened under section 2047 of Act No. 218 of the Public Acts of 1956, being section 500.2047 of the Michigan Compiled Laws, and may bind a health care corporation to any rules promulgated as provided in that section.

(7) Nothing in this section shall alter or supersede any provider class plan established pursuant to part 5.

(8) If the commissioner has probable cause to believe that a health care corporation is violating, or has violated subsection (1), indicating a persistent tendency to engage in conduct prohibited by that subsection, or has probable cause to believe that a health care corporation is violating, or has violated subsection (2), (3), or (4), he or she shall give written notice to the corporation, pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws, setting forth the general nature of the complaint against the corporation and the proceedings contemplated under this section. Before the issuance of a notice of hearing, the staff of the bureau of insurance responsible for the matters which would be at issue in the hearing shall give the corporation an opportunity to confer and discuss the possible complaint and proceedings in person with the commissioner or a representative of the commissioner, and the matter may be disposed of summarily upon agreement of the parties. This subsection shall not be construed to diminish the right of a person to bring an action for damages under this section.

(9) A hearing held pursuant to subsection (8) shall be held in accordance with section 2030 of the insurance code of 1956, Act No. 218 of the Public Acts of 1956, as amended, being section 500.2030 of the Michigan Compiled Laws. The hearing shall be held pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969. If, after the hearing, the commissioner determines that the health care corporation is violating, or has violated subsection (1), indicating a persistent tendency to engage in conduct prohibited by that subsection, or is violating, or has violated subsection (2), (3), or (4), the commissioner shall reduce his or her findings and decision to writing, and shall issue and cause to be served upon the corporation a copy of the findings and an order requiring the corporation to cease and desist from engaging in the prohibited activity. The commissioner may at any time, by order, and after notice and opportunity for a hearing, reopen and alter, modify, or set aside, in whole or in part, an order issued by him or her under this subsection, when in his or her opinion conditions of fact or law have so changed as to require that action, or if the public interest so requires.

(10) A health care corporation which violates a cease and desist order of the commissioner issued under subsection (9), after notice and an opportunity for a hearing, and upon order of the commissioner, may be subject to a civil fine of not more than $10,000.00 for each violation.

(11) In addition to other remedies provided by law, an aggrieved member may bring an action for actual monetary damages sustained as a result of a violation of this section. If successful on the merits, the member shall be awarded actual monetary damages or $200.00, whichever is greater, together with reasonable attorneys' fees. If the health care corporation shows by a preponderance of the evidence that a violation of this section resulted from a bona fide error notwithstanding the maintenance of procedures reasonably adapted to avoid the error, the amount of recovery shall be limited to actual monetary damages.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1989, Act 132, Eff. Nov. 1, 1989.

Constitutionality: This act is unconstitutional in the following three particulars:

The Supreme Court ruling on these three areas of this act does not affect the constitutionality of the remainder of the act. Where, as here, the unconstitutional provisions are easily severable, the remainder of the act need not be affected. Blue Cross and Blue Shield of Michigan v. Governor, 422 Mich. 1 (1985).

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1402a Terms and conditions of certificate; form; description; requested information; written request; "board certified" defined.

Sec. 402a. (1) A health care corporation shall provide a written form in plain English to subscribers upon enrollment that describes the terms and conditions of the corporation's certificate. The form shall provide a clear, complete, and accurate description of all of the following, as applicable:

(a) The service area.

(b) Covered benefits, including prescription drug coverage, with specifications regarding requirements for the use of generic drugs.

(c) Emergency health coverages and benefits.

(d) Out-of-area coverages and benefits.

(e) An explanation of member financial responsibility for copayments, deductibles, and any other out-of-pocket expenses.

(f) Provision for continuity of treatment if a provider's participation terminates during the course of a member's treatment by that provider.

(g) The telephone number to call to receive information concerning member grievance procedures.

(h) How the covered benefits apply in the evaluation and treatment of pain.

(i) A summary listing of the information available pursuant to subsection (2).

(2) A health care corporation shall provide upon request to members for services offered pursuant to section 502a a clear, complete, and accurate description of any of the following information that has been requested:

(a) The current provider network in the certificate's service area, including names and locations of participating providers by specialty or type of practice, a statement of limitations of accessibility and referrals to specialists, and a disclosure of which providers will not accept new members.

(b) The professional credentials of participating health professionals, including, but not limited to, participating health professionals who are board certified in pain medicine and the evaluation and treatment of pain and have reported that certification to the health care corporation, including all of the following:

(*i*) Relevant professional degrees.

(*ii*) Date of certification by the applicable nationally recognized boards and other professional bodies.

(*iii*) The names of licensed facilities on the provider panel where the health professional presently has privileges

for the treatment, illness, or procedure that is the subject of the request.

(c) The licensing verification telephone number for the Michigan department of consumer and industry services that can be accessed for information as to whether any disciplinary actions or open formal complaints have been taken or filed against a health care provider in the immediately preceding 3 years.

(d) Any prior authorization requirements and any limitations, restrictions, or exclusions, including, but not limited to, drug formulary limitations and restrictions by category of service, benefit, and provider, and, if applicable, by specific service, benefit, or type of drug.

(e) Indication of the financial relationships between the health care corporation and any closed provider panel including all of the following as applicable:

(*i*) Whether a fee-for-service arrangement exists, under which the provider is paid a specified amount for each covered service rendered to the participant.

(*ii*) Whether a capitation arrangement exists, under which a fixed amount is paid to the provider for all covered services that are or may be rendered to each covered individual or family.

(*iii*) Whether payments to providers are made based on standards relating to cost, quality, or patient satisfaction.

(f) A telephone number and address to obtain from the health care corporation additional information concerning the items described in subdivisions (a) to (e).

(3) Upon request, any of the information provided under subsection (2) shall be provided in writing. A health care corporation may require that a request under subsection (2) be submitted in writing.

(4) As used in this section, "board certified" means certified to practice in a particular medical or other health profession specialty by the American board of medical specialties or other national health professional organization.

History: Add. 1996, Act 516, Eff. Oct. 1, 1997;—Am. 1998, Act 426, Eff. Apr. 1, 1999;—Am. 2001, Act 242, Imd. Eff. Jan. 8, 2002.

Compiler's note: Enacting section 1 of Act 242 of 2001 provides:

"Enacting section 1. The 2001 amendatory act that added section 402a(4) to the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1402a, shall not be construed as creating a new mandated benefit for any coverages issued under the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704."

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1402b Preexisting condition limitation or exclusion; prohibition; exception; "group" defined.

Sec. 402b. (1) For an individual covered under a nongroup certificate or under a certificate not covered under subsection (2), a health care corporation may exclude or limit coverage for a condition only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 6 months after the effective date of the certificate.

(2) A health care corporation shall not exclude or limit coverage for a preexisting condition for an individual covered under a group certificate.

(3) Notwithstanding subsection (1), a health care corporation shall not issue a certificate to a person eligible for nongroup coverage or eligible for a certificate not covered under subsection (2) that excludes or limits coverage for a preexisting condition or provides a waiting period if all of the following apply:

(a) The person's most recent health coverage prior to applying for coverage with the health care corporation was under a group health plan.

(b) The person was continuously covered prior to the application for coverage with the health care corporation under 1 or more health plans for an aggregate of at least 18 months with no break in coverage that exceeded 62 days.

(c) The person is no longer eligible for group coverage and is not eligible for medicare or medicaid.

(d) The person did not lose eligibility for coverage for failure to pay any required contribution or for an act to defraud a health care corporation, a health insurer, or a health maintenance organization.

(e) If the person was eligible for continuation of health coverage from that group health plan pursuant to the consolidated omnibus budget reconciliation act of 1985, Public Law 99-272, 100 Stat. 82, he or she has elected and exhausted that coverage.

(4) As used in this section, "group" means a group of 2 or more subscribers.

History: Add. 1996, Act 516, Eff. Oct. 1, 1997;—Am. 1999, Act 7, Imd. Eff. Mar. 9. 1999.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1402c Termination of participation between primary care physician and health care

corporation; notice to member; effect of termination; definitions.

Sec. 402c. (1) If participation between a primary care physician and a health care corporation terminates, the physician may provide written notice of this termination within 15 days after the physician becomes aware of the termination to each member who has chosen the physician as his or her primary care physician. If a member is in an ongoing course of treatment with any other physician who is participating with the health care corporation and the participation between the physician and the health care corporation terminates, the physician may provide written notice of this termination to the member within 15 days after the physician becomes aware of the termination. The notices under this subsection may also describe the procedure for continuing care under subsections (2) and (3).

(2) If participation between a member's current physician and a health care corporation terminates, the health care corporation shall permit the member to continue an ongoing course of treatment with that physician as follows:

(a) For 90 days from the date of notice to the member by the physician of the physician's termination with the health care corporation.

(b) If the member is in her second or third trimester of pregnancy at the time of the physician's termination, through postpartum care directly related to the pregnancy.

(c) If the member is determined to be terminally ill prior to a physician's termination or knowledge of the termination and the physician was treating the terminal illness before the date of termination or knowledge of the termination, for the remainder of the member's life for care directly related to the treatment of the terminal illness.

(3) Subsection (2) applies only if the physician agrees to all of the following:

(a) To participate on a per claim basis and to accept as payment in full reimbursement from the health care corporation at the rates applicable prior to the termination.

(b) To adhere to the health care corporation's standards for maintaining quality health care and to provide to the health care corporation necessary medical information related to the care.

(c) To otherwise adhere to the health care corporation's policies and procedures, including, but not limited to, those concerning utilization review, referrals, preauthorizations, and treatment plans.

(4) A health care corporation shall provide written notice to each participating physician that if participation between the physician and the health care corporation terminates, the physician may do both of the following:

(a) Notify the health care corporation's members under the care of the physician of the termination if the physician does so within 15 days after the physician becomes aware of the termination.

(b) Include in the notice under subdivision (a) a description of the procedures for continuing care under subsections (2) and (3).

(5) This section does not create an obligation for a health care corporation to provide to a member coverage beyond the maximum coverage limits permitted by the health care corporation's certificate with the member. This section does not create an obligation for a health care corporation to expand who may be a primary care physician under a certificate.

(6) As used in this section:

(a) "Physician" means an allopathic physician, osteopathic physician, or podiatric physician.

(b) "Terminal illness" means that term as defined in section 5653 of the public health code, 1978 PA 368, MCL 333.5653.

(c) "Terminates" or "termination" includes the nonrenewal, expiration, or ending for any reason of a participation agreement between a physician and a health care corporation, but does not include a termination by the health care corporation for failure to meet applicable quality standards or for fraud.

History: Add. 1999, Act 228, Eff. July 1, 2000;—Am. 2000, Act 485, Imd. Eff. Jan. 11, 2001.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1403 Payment of benefits; interest; claim form; exception.

Sec. 403. (1) A health care corporation, on a timely basis, shall pay to a member benefits as are entitled and provided under the applicable certificate. When not paid on a timely basis, benefits payable to a member shall bear simple interest from a date 60 days after a satisfactory claim form was received by the health care corporation, at a rate of 12% interest per annum. The interest shall be paid in addition to, and at the time of payment of, the claim. Section 2006(7) to (14) of the insurance code of 1956, 1956 PA 218, MCL 500.2006, applies to a health care corporation.

(2) A health care corporation shall specify in writing the materials that constitute a satisfactory claim form not later than 30 days after receipt of a claim, unless the claim is settled within 30 days. If a claim form is not supplied as to the entire claim, the amount supported by the claim form shall be considered to be paid on a timely basis if

paid within 60 days after receipt of the claim form by the corporation. This subsection does not apply to a health care corporation when paying a claim under section 2006(7) to (14) of the insurance code of 1956, 1956 PA 218, MCL 500.2006.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 2002, Act 317, Eff. Oct. 1, 2002.

Compiler's note: Enacting section 1 of Act 317 of 2002 provides:

"Enacting section 1. This amendatory act takes effect on October 1, 2002 and applies to all health care claims with dates of service on and after October 1, 2002."

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1403a Benefits paid by check or written instrument; escheat.

Sec. 403a. Benefits paid by a health care corporation to a subscriber or provider by way of a check or other similar written instrument for the transmission or payment of money, that is not cashed within the period prescribed in the uniform unclaimed property act, shall escheat to the state pursuant to the uniform unclaimed property act.

History: Add. 1990, Act 172, Imd. Eff. July 2, 1990;—Am. 1995, Act 49, Eff. Jan. 1, 1996.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1403b Advertising material prohibited.

Sec. 403b. A health care corporation shall not include in any bill for services or products any advertising material for any other service or product sold by a subsidiary of the corporation.

History: Add. 2003, Act 59, Eff. July 23, 2003.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1404 Violation of § 550.1402 or § 550.1403; private informal managerial-level conference; review by commissioner; internal procedures; determination by commissioner; expedited grievance procedure; procedural rules; hearing matter as contested case; authorization to act on behalf of member.

Sec. 404. (1) A person who has reason to believe that a health care corporation has violated section 402 or 403, if the violation was with respect to an action or inaction of the corporation with respect to that person, is entitled to a private informal managerial-level conference with the corporation, and to a review before the commissioner or his or her designee through September 30, 2000 and beginning October 1, 2000 before an independent review organization under the patient's right to independent review act, if the conference fails to resolve the dispute.

(2) A health care corporation shall establish reasonable internal procedures to provide a person with a private informal managerial-level conference as provided in subsection (1). These procedures shall provide all of the following:

(a) That a final determination will be made in writing by the health care corporation not later than 35 calendar days after a grievance is submitted in writing by the member. The timing for the 35-calendar-day period may be tolled, however, for any period of time the member is permitted to take under the grievance procedure and for a period of time that shall not exceed 10 days if the health care corporation has not received requested information from a health provider.

(b) A method of providing the person, upon request and payment of a reasonable copying charge, with information pertinent to the denial of a certificate or to the rate charged.

(c) A method for resolving the dispute promptly and informally, while protecting the interests of both the person and the corporation.

(d) That when an adverse determination is made, a written statement in plain English containing the reasons for the adverse determination is provided to the member along with written notifications as required under the patient's right to independent review act.

(e) A method for providing summary data on the number and types of complaints and grievances filed. Beginning April 15, 2001, this summary data for the prior calendar year shall be filed annually with the commissioner on forms provided by the commissioner.

(3) If the health care corporation fails to provide a conference and proposed resolution within 30 days after a request by a person, or if the person disagrees with the proposed resolution of the corporation after completion of the conference, the person is entitled to a determination of the matter by the commissioner or his or her designee through September 30, 2000 and beginning October 1, 2000 by an independent review organization under the

patient's right to independent review act.

(4) A health care corporation shall establish, as part of its internal procedures, an expedited grievance procedure. The expedited grievance procedure shall provide that a determination will be made by the health care corporation not later than 72 hours after receipt of the grievance. Within 10 days after receipt of a determination, the member may request a determination of the matter by the commissioner or his or her designee through September 30, 2000 and beginning October 1, 2000 by an independent review organization under the patient's right to independent review act. If the determination by the health care corporation is made orally, the health care corporation shall provide a written confirmation of the determination to the member not later than 2 business days after the oral determination. An expedited grievance under this subsection applies if a grievance is submitted and a physician, orally or in writing, substantiates that the time frame for a grievance under subsections (1) to (3) would seriously jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function. This subsection does not apply to a provider's complaint concerning claims payment, handling, or reimbursement for health care services. As used in this section, “grievance” means an oral or written statement, by a member to the health care corporation that the health care corporation has wrongfully refused or failed to respond in a timely manner to a request for benefits or payment.

(5) The commissioner shall by rule establish a procedure for determination under this section, which shall be reasonably calculated to resolve these matters informally and as rapidly as possible, while protecting the interests of both the person and the health care corporation.

(6) If either the health care corporation or a person other than a member disagrees with a determination of the commissioner or his or her designee under this section, the commissioner or his or her designee, if requested to do so by either party, shall proceed to hear the matter as a contested case under the administrative procedures act.

(7) A member may authorize in writing any person, including, but not limited to, a physician, to act on his or her behalf at any stage in a grievance proceeding under this section.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1996, Act 516, Eff. Oct. 1, 1997;—Am. 2000, Act 250, Imd. Eff. June 29, 2000.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1405 Single billing form; development; explanation of total bill for services.

Sec. 405. (1) A health care corporation, in consultation with the department of social services, shall develop a single billing form to be used for the billing of each of the following: hospital services, physician services, and pharmaceutical services. If such forms are subsequently developed by the federal government, they may be used in the place of forms developed pursuant to this subsection.

(2) A health care corporation shall provide each member with a detailed and accurate explanation of his or her total bill for services rendered by a health care provider and provided under a certificate with a health care corporation, including charges for specific types of services rendered, the date of services rendered, the amounts reimbursed by the corporation, and the reasons for denial of any payments for expenses incurred.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1406 Confidentiality of records; disclosures; consent; policy regarding protection of privacy and confidentiality of personal data; violation as misdemeanor; penalty; civil action for damages; effect of section on governmental agencies.

Sec. 406. (1) A health care corporation shall, in order to ensure the confidentiality of records containing personal data that may be associated with identifiable members, use reasonable care to secure these records from unauthorized access and to collect only personal data that are necessary for the proper review and payment of claims. Except as is necessary to comply with section 603 or for the purpose of claims adjudication, claims verification, or when required by law, a health care corporation shall not disclose records containing personal data that may be associated with an identifiable member, or personal information concerning a member, to a person other than the member, without the prior and specific informed consent of the member to whom the data or information pertains. The member's consent shall be in writing. Except when a disclosure is made to the commissioner or another governmental agency, a court, or any other governmental entity, a health care corporation shall make a disclosure for which prior and specific informed consent is not required upon the condition that the person to whom the disclosure is made protect and use the disclosed data or information only in the manner authorized by the corporation, pursuant to subsection (2). If a member has authorized the release of personal data to

a specific person, a health care corporation shall make a disclosure to that person upon the condition that the person shall not release the data to a third person unless the member executes in writing another prior and specific informed consent authorizing the additional release. This subsection shall not preclude the release of information to a member, pertaining to that member, by telephone, if the identity of the member is verified. This subsection shall not preclude a representative of a subscriber group, upon request of a member of that subscriber group, or an elected official, upon request of a constituent, from assisting the individual in resolving a claim.

(2) The board of directors of a health care corporation shall establish and make public the policy of the corporation regarding the protection of the privacy of members and the confidentiality of personal data. The policy, at a minimum, shall do all of the following:

(a) Provide for the corporation's implementation of provisions in this act and other applicable laws respecting collection, security, use, release of, and access to personal data.

(b) Identify the routine uses of personal data by the corporation; prescribe the means by which members will be notified regarding such uses; and provide for notification regarding the actual release of personal data and information that may be identified with, or that concern, a member, upon specific request by that member. As used in this subdivision, “routine use” means the ordinary use or release of personal data compatible with the purpose for which the data were collected.

(c) Assure that no person shall have access to personal data except on the basis of a need to know.

(d) Establish the contractual or other conditions under which the corporation will release personal data.

(e) Provide that enrollment applications and claim forms developed by the corporation shall contain a member's consent to the release of data and information that is limited to the data and information necessary for the proper review and payment of claims, and shall reasonably notify members of their rights pursuant to the board's policy and applicable law.

(f) Provide that applicants for new or renewed certificates shall be advised that the corporation does not require the use of the applicant's federal social security account number and that, when applicable, another authority does require use of the number.

(3) A health care corporation which violates this section is guilty of a misdemeanor, punishable by a fine of not more than $1,000.00 for each violation.

(4) A member may bring a civil action for damages against a health care corporation for a violation of this section and may recover actual damages or $200.00, whichever is greater, together with reasonable attorneys' fees and costs.

(5) This section shall not be construed to limit access to records or to enlarge or diminish the investigative and examination powers of governmental agencies, as provided for by law.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1407 Complaint system; procedures; response to complaint; access to complaints and responses; record of complaints; annual report; other legal remedies.

Sec. 407. (1) A health care corporation shall establish and maintain a complaint system which affords adequate and reasonable procedures for the expeditious resolution of written complaints initiated by members concerning any matter relating to the provisions of a certificate. At a minimum, procedures shall be developed by a corporation for the resolution of claims for reimbursement; denial, cancellations, or nonrenewals of certificates; and complaints regarding the quality of the services delivered by health care providers and health care facilities which receive reimbursement from the corporation.

(2) A health care corporation, within 30 days after receipt of written complaint, shall give a reasonable written response to each written complaint which it receives. The commissioner shall have free access, as defined in section 603(2), to complaints and responses, which shall be made available to the commissioner for inspection. If the matter complained of is reasonably believed by the complainant to be a violation of section 402 or 403, the complainant shall be entitled to a private informal managerial-level conference with the health care corporation, as provided for in section 404.

(3) The health care corporation shall maintain a complete record of all of the written complaints of its members which the corporation has received since the date of the last examination. This record shall indicate the total number of complaints; and by line of business, the nature of each complaint, the disposition of each complaint, and the time taken to process each complaint.

(4) A health care corporation shall submit to the commissioner an annual report which describes the complaint

system of the corporation, and includes a compilation and analysis of the written complaints filed with the corporation, their disposition and underlying causes, and measures being implemented to alleviate those causes. The report shall be compiled in a manner which protects an individual's right to privacy with respect to medical information and shall not disclose the identity of a member by name or other personal identifier without the member's consent pursuant to section 406(1). The annual report shall be a public record.

(5) This section shall not prevent a member from seeking other remedies available by law.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1408 False, dishonest, or fraudulent claim for payment as misdemeanor; penalty; civil action; prosecution.

Sec. 408. Any provider, member, or other person who knowingly makes, presents, or causes to be presented to a health care corporation any false, dishonest, or fraudulent claim for payment to or from the health care corporation, is guilty of a misdemeanor, punishable by a fine of not more than $1,000.00 or imprisonment for not more than 3 months, or both. This section shall not preclude a civil action for recovery of money due the corporation, nor shall it preclude the prosecution of any such provider, member, or other person under the applicable provisions of Act No. 328 of the Public Acts of 1931, as amended, being sections 750.1 to 750.568 of the Michigan Compiled Laws.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1409 Civil action for negligence.

Sec. 409. A civil action for negligence based upon, or arising out of, the health care provider-patient relationship shall not be maintained against a health care corporation.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1410 Certificate providing coverage of dependent terminating at specified age; exception.

Sec. 410. Any certificate issued by a health care corporation which provides that coverage of a dependent of the subscriber terminates at a specified age shall not terminate with respect to an unmarried child who is incapable of self-sustaining employment by reason of mental retardation or physical disability, if the following conditions are met:

(a) The child became incapable before 19 years of age and is chiefly dependent upon the subscriber for support and maintenance.

(b) Before the child turns 19 years of age, or within 31 days thereafter, the subscriber has submitted proof of the dependent's incapacity to the corporation.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1998, Act 24, Imd. Eff. Mar. 12, 1998.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1410a Provisions of group certificate; electing coverage under group conversion certificate; notice of conversion privilege; requirements of group conversion certificate; premium; issuance; compliance.

Sec. 410a. (1) A group certificate that is issued or renewed in this state after December 31, 1990 shall include provisions consistent with this section.

(2) If an individual subscriber has been continuously covered under a group certificate for at least 3 months immediately prior to termination, the individual subscriber and his or her covered spouse and dependents may elect coverage under a group conversion certificate upon termination. As used in this section, termination includes, but is not limited to, the following:

(a) Discontinuance of a group certificate in its entirety or with respect to a covered class.

(b) Loss of coverage due to voluntary or involuntary termination of employment except for termination of employment because of gross misconduct.

(c) For a surviving spouse or dependent, death of an individual subscriber covered under a group certificate.

(d) An event that causes a person, who is a spouse or dependent of an individual subscriber at the time of the

event, to cease to be a qualified family member under a group certificate.

(3) Coverage under a group conversion certificate shall take effect immediately upon the termination of coverage under the group certificate.

(4) Notification of the conversion privilege shall be included in each certificate of coverage.

(5) A master certificate holder shall give written notice to an individual subscriber of the option to elect a group conversion certificate within 14 days after the occurrence of subsection (2)(a) or (b).

(6) An individual subscriber shall notify the health care corporation of his or her election to convert to a group conversion certificate not later than 30 days after termination of coverage. The first premium shall be paid to the health care corporation at the time the individual elects to convert to a group conversion certificate.

(7) A group conversion certificate under this section:

(a) Shall be issued without evidence of insurability.

(b) Shall not use conditions pertaining to health as a basis for classification.

(c) Shall not exclude a preexisting condition that is not excluded by the group certificate solely because it is a preexisting condition.

(d) May provide that benefits may be reduced by the amount of benefits paid for a specific covered service pursuant to the group certificate that has been terminated.

(8) The premium for a group conversion certificate under this section shall be determined using the aggregate experience for all such certificates issued in this state by the health care corporation and in accordance with premium rates applicable to the age, class of risk, and the type and amount of coverage provided. The experience of an individual under a group conversion certificate shall not be an acceptable basis for establishing that individual's rate for his or her group conversion certificate.

(9) A health care corporation is not required to issue a group conversion certificate under this section if any of the following circumstances apply:

(a) The individual is covered for similar benefits and to a similar extent by another expense-incurred hospital, medical, surgical, or sick-care insurance policy or certificate, hospital or medical service subscriber contract, medical practice or other prepayment plan, or other expense-incurred plan or program.

(b) The individual is covered under title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395 to 1395b, 1395b-2, 1395c to 1395i, 1395i-1a to 1395i-3, 1395j to 1395dd, 1395ff to 1395mm, and 1395oo to 1395ccc.

(c) If termination of an individual's coverage under a group certificate occurred because of any of the following:

(*i*) The individual failed to pay any required contribution.

(*ii*) Discontinued group coverage was replaced by group coverage.

(*iii*) The individual acted to defraud the health care corporation.

(10) A group conversion certificate under this section delivered outside this state for a group certificate that was issued and delivered in this state shall comply with this section.

History: Add. 1989, Act 260, Imd. Eff. Dec. 26, 1989.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1411—550.1413a Repealed. 1994, Act 40, Imd. Eff. Mar. 14, 1994.

Compiler's note: The repealed sections pertained to supplemental medicare benefits certificate without preexisting condition exclusion or limitation, medicare supplemental buyer's guide, certificate to complement federal medicare program, and condition to issuance of certificate.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1414 Expired. 1980, Act 430, Eff. Jan. 1, 1982.

Compiler's note: The expired section pertained to treatment of alcoholism and drug abuse.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1414a Treatment of substance abuse; contracts; qualifications of provider; coverage for intermediate and outpatient care for substance abuse required; demonstration projects; substance abuse advisory committee; report; contracts based on final report; reimbursement; group and nongroup certificates; exceptions; option to decline coverage; charges, terms, and conditions; reduction of coverage; deductibles and copayment provision; minimum coverage; adjustment; definitions; effective date of section.

Sec. 414a. (1) A health care corporation shall offer benefits for the inpatient treatment of substance abuse by a licensed allopathic physician or a licensed osteopathic physician in a health care facility operated by this state or approved by the department of public health for the hospitalization for, or treatment of, substance abuse.

(2) Subject to subsections (3), (5), and (7), a health care corporation may enter into contracts with providers for the rendering of inpatient substance abuse treatment by those providers.

(3) A contracting provider rendering inpatient substance abuse treatment for patients other than adolescent patients shall be a licensed hospital or a substance abuse service program licensed under article 6 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.6101 to 333.6523 of the Michigan Compiled Laws, and shall meet the standards set by the corporation for contracting health care facilities.

(4) A health care corporation shall provide coverage for intermediate and outpatient care for substance abuse, upon issuance or renewal, in all group and nongroup certificates other than service-specific certificates, such as certificates providing coverage solely for 1 of the following: dental care; hearing care; vision care; prescription drugs; or another type of health care benefit. Subject to subsections (5) and (7), a health care corporation may enter into contracts with providers for the rendering of intermediate care, outpatient care, or both types of care, for the treatment of substance abuse.

(5) A health care corporation shall enter into and maintain 5-year contracts with not less than 5 providers in this state, as demonstration projects pursuant to section 207(1)(b), for the rendering of inpatient, intermediate, and outpatient care to adolescent substance abuse patients. A provider who contracts with a health care corporation for the rendering of inpatient, intermediate, and outpatient care to adolescent substance abuse patients shall meet all of the following requirements:

(a) Is accredited by the joint commission on accreditation of hospitals, the council on accreditation for families and children, the commission on accreditation of rehabilitation facilities, or the American osteopathic association.

(b) If applicable, has obtained a certificate of need under part 221 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.22101 to 333.22181 of the Michigan Compiled Laws.

(c) Is licensed by the office of substance abuse services under article 6 of the public health code, Act No. 368 of the Public Acts of 1978.

(d) Is licensed by the department of social services as a child caring institution under Act No. 116 of the Public Acts of 1973, being sections 722.111 to 722.128 of the Michigan Compiled Laws.

(e) Agrees to follow generally accepted accounting principles and practices.

(f) Agrees to supply all data required to fulfill the objectives of the demonstration program.

(g) Agrees to work with the substance abuse advisory committee and the health care corporation in conducting the evaluation of the demonstration program.

(6) The substance abuse advisory committee is established, with the cooperation of the office of substance abuse services, under the direction of the office of health and medical affairs. The committee shall consist of 7 members to include the director of the office of health and medical affairs or his or her designee, the administrator of the office of substance abuse services or his or her designee, a representative of the department of public health, 2 designees of the chief executive officer of a health care corporation contracting for a demonstration project under subsection (5), a member of the family of an adolescent substance abuser to be appointed by the office of health and medical affairs, and a service provider of an adolescent substance abuse treatment program to be appointed by the office of health and medical affairs. The substance abuse advisory committee shall evaluate each demonstration project and shall report at the conclusion of each demonstration project to the senate and house standing committees responsible for public health issues. A final report of all the demonstration projects shall be issued by not later than December 31, 1994, and shall include evaluations of and recommendations concerning all of the following:

(a) The cost of specialized adolescent substance abuse treatment compared with the effectiveness of adolescent substance abuse treatment.

(b) The cost and effectiveness of the different levels of adolescent substance abuse treatment, including inpatient, intermediate, and outpatient care and aftercare programs.

(7) Based on the final report submitted pursuant to subsection (6), beginning December 31, 1994, a health care corporation shall continue to enter into and maintain contracts with not less than 5 providers in this state, and may enter into additional contracts for the rendering of inpatient, intermediate, and outpatient care to adolescent substance abuse patients if the provider meets the requirements of subsection (5)(a) to (e). Contracts entered into under this subsection shall be based upon the recommendations of the final report submitted pursuant to subsection (6).

(8) A health care corporation shall reimburse providers for the rendering of inpatient, intermediate, and outpatient care to adolescent substance abuse patients at a rate that shall be commensurate with reimbursement rates for other

similar providers rendering inpatient, intermediate, and outpatient care to adolescent substance abuse patients.

(9) In the case of group certificates, if the amount due for a group certificate would be increased by 3% or more because of the provision of the coverage required under subsection (4), the master policyholder shall have the option to decline the coverage required to be provided under subsection (4). In the case of nongroup certificates, if the total amount due for all nongroup certificates of the health care corporation would be increased by 3% or more because of the provision of the coverage required under subsection (4), the subscriber for each such certificate shall have the option to decline the coverage required to be provided under subsection (4).

(10) Charges, terms, and conditions for the coverage for intermediate and outpatient care for substance abuse required to be provided under subsection (4) shall not be less favorable than the maximum prescribed for any other comparable service.

(11) The coverage for intermediate and outpatient care for substance abuse required to be provided under subsection (4) shall not be reduced by terms or conditions which apply to other items of coverage in a certificate, group or nongroup. This subsection shall not be construed to prohibit certificates that provide for deductibles and copayment provisions for coverage for intermediate and outpatient care for substance abuse, as approved by the commissioner.

(12) The coverage for intermediate and outpatient care for substance abuse required to be provided under subsection (4) shall, at a minimum, provide for up to $1,500.00 in health care benefits for intermediate and outpatient care for substance abuse per member per year. This minimum shall be adjusted by March 31, 1982 and by March 31 each year thereafter in accordance with the annual average percentage increase or decrease in the United States consumer price index for the 12-month period ending the preceding December 31.

(13) As used in this section:

(a) "Adolescent" means an individual who is less than 18 years of age, but more than 11 years of age.

(b) "Intermediate care" means the use, in a full 24-hour residential therapy setting, or in a partial, less than 24-hour, residential therapy setting, of any or all of the following therapeutic techniques, as identified in a treatment plan for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs:

(*i*) Chemotherapy.

(*ii*) Counseling.

(*iii*) Detoxification services.

(*iv*) Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in a treatment plan.

(c) "Outpatient care" means the use, on both a scheduled and a nonscheduled basis, of any or all of the following therapeutic techniques, as identified in a treatment plan for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs:

(*i*) Chemotherapy.

(*ii*) Counseling.

(*iii*) Detoxification services.

(*iv*) Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in a treatment plan.

(d) "Substance abuse" means that term as defined in section 6107 of the public health code, Act No. 368 of the Public Acts of 1978, being section 333.6107 of the Michigan Compiled Laws.

History: Add. 1980, Act 430, Eff. Jan. 1, 1982;—Am. 1988, Act 345, Imd. Eff. Oct. 25, 1988.

Constitutionality: This act is unconstitutional in the following three particulars:

The Supreme Court ruling on these three areas of this act does not affect the constitutionality of the remainder of the act. Where, as here, the unconstitutional provisions are easily severable, the remainder of the act need not be affected. Blue Cross and Blue Shield of Michigan v. Governor, 422 Mich. 1 (1985).

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1415 Benefits for prosthetic devices.

Sec. 415. (1) Not later than 12 months after the effective date of this act, a health care corporation shall offer or include coverage, in all group and nongroup certificates, to provide benefits for prosthetic devices to maintain or replace the body part of an individual whose covered illness or injury has required the removal of that body part. However, certificates resulting from collective bargaining agreements shall be exempted from this subsection. This coverage shall provide that reasonable charges for medical care and attendance for an individual fitted with a prosthetic device shall be covered benefits after the individual's attending physician has certified the medical necessity or desirability for a proposed course of rehabilitative treatment.

(2) Not later than 12 months after the effective date of this act, a health care corporation shall include coverage, in all group and nongroup certificates, to provide benefits for prosthetic devices to maintain or replace the body part of an individual who has undergone a mastectomy. This coverage shall provide that reasonable charges for medical care and attendance for an individual who receives reconstructive surgery following a mastectomy or who is fitted with a prosthetic device shall be covered benefits after the individual's attending physician has certified the medical necessity or desirability of a proposed course of rehabilitative treatment. The cost and fitting of a prosthetic device following a mastectomy is included within the type of coverage intended by this subsection.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Constitutionality: This act is unconstitutional in the following three particulars:

The Supreme Court ruling on these three areas of this act does not affect the constitutionality of the remainder of the act. Where, as here, the unconstitutional provisions are easily severable, the remainder of the act need not be affected. Blue Cross and Blue Shield of Michigan v. Governor, 422 Mich. 1 (1985).

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1416 Coverage for breast cancer diagnostic services, breast cancer outpatient services, and breast cancer rehabilitative services; coverage for breast cancer screening mammography; definitions; effective date of section.

Sec. 416. (1) Subject to dollar limits, deductibles, and coinsurance provisions that are not less favorable than those for physical illness generally, a health care corporation shall offer or include, in each group and nongroup certificate, coverage for breast cancer diagnostic services, breast cancer outpatient treatment services, and breast cancer rehabilitative services.

(2) Subject to dollar limits, deductibles, and coinsurance provisions that are not less favorable than those for physical illness generally, a health care corporation shall offer or include, in each group and nongroup certificate, the following coverage for breast cancer screening mammography:

(a) If performed on a woman 35 years of age or older and under 40 years of age, coverage for 1 screening mammography examination during that 5-year period.

(b) If performed on a woman 40 years of age or older, coverage for 1 screening mammography examination every calendar year.

(3) As used in this section:

(a) "Breast cancer diagnostic services" means a procedure intended to aid in the diagnosis of breast cancer, delivered on an inpatient or outpatient basis, including but not limited to mammography, surgical breast biopsy, and pathologic examination and interpretation.

(b) "Breast cancer rehabilitative services" means a procedure intended to improve the result of, or ameliorate the debilitating consequences of, treatment of breast cancer, delivered on an inpatient or outpatient basis, including but not limited to, reconstructive plastic surgery, physical therapy, and psychological and social support services.

(c) "Breast cancer screening mammography" means a standard 2-view per breast, low-dose radiographic examination of the breasts, using equipment designed and dedicated specifically for mammography, in order to detect unsuspected breast cancer.

(d) "Breast cancer outpatient treatment services" means a procedure intended to treat cancer of the human breast, delivered on an outpatient basis, including but not limited to surgery, radiation therapy, chemotherapy, hormonal therapy, and related medical follow-up services.

(4) This section shall take effect November 1, 1989.

History: Add. 1989, Act 57, Eff. Nov. 1, 1989.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1416a Coverage for drug used in antineoplastic therapy and cost of its administration; conditions.

Sec. 416a. A health care corporation shall provide coverage in each group and nongroup certificate for a federal food and drug administration approved drug used in antineoplastic therapy and the reasonable cost of its administration. Coverage shall be provided regardless of whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug has received approval by the federal food and drug administration if all of the following conditions are met:

(a) The drug is ordered by a physician for the treatment of a specific type of neoplasm.

(b) The drug is approved by the federal food and drug administration for use in antineoplastic therapy.

(c) The drug is used as part of an antineoplastic drug regimen.

(d) Current medical literature substantiates its efficacy and recognized oncology organizations generally accept the treatment.

(e) The physician has obtained informed consent from the patient for the treatment regimen which includes federal food and drug administration approved drugs for off-label indications.

History: Add. 1989, Act 57, Imd. Eff. June 16, 1989.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1416b Establishment of program to prevent onset of clinical diabetes required; report; coverages; "diabetes" defined.

Sec. 416b. (1) A health care corporation shall establish and provide to members and participating providers a program to prevent the onset of clinical diabetes. This program for participating providers shall emphasize best practice guidelines to prevent the onset of clinical diabetes and to treat diabetes, including, but not limited to, diet, lifestyle, physical exercise and fitness, and early diagnosis and treatment.

(2) A health care corporation shall regularly measure the effectiveness of a program provided pursuant to subsection (1) by regularly surveying group and nongroup members covered by the certificate. Not later than 2 years after the effective date of the amendatory act that added this section, each health care corporation shall prepare a report containing the results of the survey and shall provide a copy of the report to the department of community health.

(3) A health care corporation certificate shall provide benefits in each group and nongroup certificate for the following equipment, supplies, and educational training for the treatment of diabetes, if determined to be medically necessary and prescribed by an allopathic or osteopathic physician:

(a) Blood glucose monitors and blood glucose monitors for the legally blind.

(b) Test strips for glucose monitors, visual reading and urine testing strips, lancets, and spring-powered lancet devices.

(c) Insulin.

(d) Syringes.

(e) Insulin pumps and medical supplies required for the use of an insulin pump.

(f) Nonexperimental medication for controlling blood sugar.

(g) Diabetes self-management training to ensure that persons with diabetes are trained as to the proper self-management and treatment of their diabetic condition.

(4) A health care corporation certificate shall provide benefits in each group and nongroup certificate for medically necessary medications prescribed by an allopathic, osteopathic, or podiatric physician and used in the treatment of foot ailments, infections, and other medical conditions of the foot, ankle, or nails associated with diabetes.

(5) Coverage under subsection (3) for diabetes self-management training is subject to all of the following:

(a) Is limited to completion of a certified diabetes education program upon occurrence of either of the following:

(*i*) If considered medically necessary upon the diagnosis of diabetes by an allopathic or osteopathic physician who is managing the patient's diabetic condition and if the services are needed under a comprehensive plan of care to ensure therapy compliance or to provide necessary skills and knowledge.

(*ii*) If an allopathic or osteopathic physician diagnoses a significant change with long-term implications in the patient's symptoms or conditions that necessitates changes in a patient's self-management or a significant change in medical protocol or treatment modalities.

(b) Shall be provided by a diabetes outpatient training program certified to receive medicare or medicaid reimbursement or certified by the department of community health. Training provided under this subdivision shall be conducted in group settings whenever practicable.

(6) Benefits under this section are not subject to dollar limits, deductibles, or copayment provisions that are greater than those for physical illness generally.

(7) As used in this section, "diabetes" includes all of the following:

(a) Gestational diabetes.

(b) Insulin-dependent diabetes.

(c) Non-insulin-dependent diabetes.

History: Add. 2000, Act 424, Eff. Mar. 28, 2001.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1416c Off-label use of approved drug; coverage; conditions; compliance; use of copayment, deductible, sanction, or utilization control; limitation; definitions.

Sec. 416c. (1) A health care corporation group or nongroup certificate that provides pharmaceutical coverage shall provide coverage for an off-label use of a federal food and drug administration approved drug and the reasonable cost of supplies medically necessary to administer the drug.

(2) Coverage for a drug under subsection (1) applies if all of the following conditions are met:

(a) The drug is approved by the federal food and drug administration.

(b) The drug is prescribed by an allopathic or osteopathic physician for the treatment of either of the following:

(*i*) A life-threatening condition so long as the drug is medically necessary to treat that condition and the drug is on the plan formulary or accessible through the health plan's formulary procedures.

(*ii*) A chronic and seriously debilitating condition so long as the drug is medically necessary to treat that condition and the drug is on the plan formulary or accessible through the health plan's formulary procedures.

(c) The drug has been recognized for treatment for the condition for which it is prescribed by 1 of the following:

(*i*) The American medical association drug evaluations.

(*ii*) The American hospital formulary service drug information.

(*iii*) The United States pharmacopoeia dispensing information, volume 1, "drug information for the health care professional".

(*iv*) Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

(3) Upon request, the prescribing allopathic or osteopathic physician shall supply to the health care corporation documentation supporting compliance with subsection (2).

(4) This section does not prohibit the use of a copayment, deductible, sanction, or a mechanism for appropriately controlling the utilization of a drug that is prescribed for a use different from the use for which the drug has been approved by the food and drug administration. This may include prior approval or a drug utilization review program. Any copayment, deductible, sanction, prior approval, drug utilization review program, or mechanism described in this subsection shall not be more restrictive than for prescription coverage generally.

(5) As used in this section:

(a) "Chronic and seriously debilitating" means a disease or condition that requires ongoing treatment to maintain remission or prevent deterioration and that causes significant long-term morbidity.

(b) "Life-threatening" means a disease or condition where the likelihood of death is high unless the course of the disease is interrupted or that has a potentially fatal outcome where the end point of clinical intervention is survival.

(c) "Off-label" means the use of a drug for clinical indications other than those stated in the labeling approved by the federal food and drug administration.

History: Add. 2002, Act 539, Eff. Jan. 22, 2003.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1417 Hospice care; contracts with health care corporation; description of benefit.

Sec. 417. (1) A health care corporation shall offer to include benefits for hospice care in each certificate that provides benefits for inpatient hospital care.

(2) A health care corporation may enter into contracts with health care providers for the rendering of hospice care. A contracting health care provider shall be a licensed hospice under article 17 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.20101 to 333.22260 of the Michigan Compiled Laws, and shall meet the standards set by the corporation for contracting health care providers.

(3) If benefits for hospice care are provided, a description of the hospice benefit shall be included in communications sent to the individual or group purchaser of coverage.

History: Add. 1984, Act 369, Eff. Jan. 1, 1986;—Am. 1994, Act 235, Imd. Eff. June 30, 1994.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1418 Emergency health services; medical coverage required; "stabilization" defined.

Sec. 418. (1) A health care corporation certificate that provides coverage for emergency health services shall

provide coverage for medically necessary services provided to a member for the sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or to a pregnancy in the case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. A health care corporation shall not require a physician to transfer a patient before the physician determines that the patient has reached the point of stabilization. A health care corporation shall not deny payment for emergency health services up to the point of stabilization provided to a member under this subsection because of either of the following:

(a) The final diagnosis.

(b) Prior authorization was not given by the health care corporation before emergency health services were provided.

(2) As used in this section, "stabilization" means the point at which no material deterioration of a condition is likely, within reasonable medical probability, to result from or occur during transfer of the patient.

History: Add. 1998, Act 124, Imd. Eff. June 10, 1998;—Am. 2004, Act 8, Imd. Eff. Feb. 20, 2004.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1419 Certificate offering dependent coverage to child; denial of enrollment on certain grounds prohibited.

Sec. 419. A health care corporation certificate that offers dependent coverage shall not deny enrollment to a subscriber's child on any of the following grounds:

(a) The child was born out of wedlock.

(b) The child is not claimed as a dependent on the subscriber's federal income tax return.

(c) The child does not reside with the subscriber or in the health care corporation's service area.

History: Add. 1995, Act 238, Eff. Mar. 28, 1996.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1419a Eligibility of parent for dependent coverage; health coverage of child through noncustodial parent; court or administrative order and notice required.

Sec. 419a. (1) If a parent is eligible for dependent coverage through a health care corporation, the health care corporation shall:

(a) Permit the parent to enroll, under the dependent coverage, a child who is otherwise eligible for coverage without regard to any enrollment season restrictions.

(b) If the parent is enrolled but fails to make application to obtain coverage for the child, enroll the child under dependent coverage upon application by the friend of the court or by the child's other parent through the friend of the court.

(c) Not eliminate the child's coverage unless premiums have not been paid as required by the certificate or the health care corporation is provided with satisfactory written evidence of either of the following:

(*i*) The court or administrative order is no longer in effect.

(*ii*) The child is or will be enrolled in comparable health coverage through another health care corporation, insurer, health maintenance organization, or self-funded health coverage plan that will take effect not later than the effective date of the cancellation of the existing coverage.

(2) If a child has health coverage through a health care corporation of a noncustodial parent, that health care corporation shall do all of the following:

(a) Provide the custodial parent with information necessary for the child to obtain benefits through that coverage.

(b) Permit the custodial parent or, with the custodial parent's approval, the provider to submit a claim for covered services without the noncustodial parent's approval.

(c) If applicable, reimburse or make payment on claims submitted by the custodial parent or medical provider for services obtained or provided under subdivision (b).

(3) This section applies only if a parent is required by a court or administrative order to provide health coverage for a child and the health care corporation is notified of that court or administrative order.

History: Add. 1995, Act 238, Eff. Mar. 28, 1996.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1419b Individual eligible under title XIX of social security act; assignment of rights of subscriber to department of social services.

Sec. 419b. (1) A health care corporation shall not consider whether an individual is eligible for or has available medical assistance under title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396g and 1396i to 1396v, in this or another state when considering eligibility for coverage or making payments under its plan for eligible subscribers.

(2) If a health care corporation has a legal liability to make payments, and payment for covered expenses for medical goods or services furnished to an individual has been made under the medical assistance program established under section 105 of the social welfare act, Act No. 280 of the Public Acts of 1939, being section 400.105 of the Michigan Compiled Laws, the department of social services has the rights of the individual to payment by the health care corporation to the extent payment was made by the department of social services's medical assistance program for those medical goods or services.

(3) If the department of social services has been assigned the rights of a subscriber who is eligible for medical assistance under section 105 of Act No. 280 of the Public Acts of 1939 and is covered by a health care corporation, the health care corporation shall not impose requirements on the department of social services that are different from requirements that apply to an agent or assignee of any other covered subscriber.

History: Add. 1995, Act 238, Eff. Mar. 28, 1996.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1420 Definitions.

Sec. 420. As used in this section and sections 421 to 430:

(a) "Applicant" means:

(*i*) For an individual long-term care certificate, the person who seeks to contract for long-term care benefits.

(*ii*) For a group long-term care certificate, the proposed member.

(b) "Group long-term care coverage" means a long-term care certificate that is delivered or issued for delivery in this state and issued to any of the following:

(*i*) One or more employers, or labor organizations, or to a trust or the trustees of a fund established by 1 or more employers or labor organizations for employees or former employees or members or former members of the labor organization.

(*ii*) A professional, trade, or occupational association for its members or former or retired members if the association is composed of individuals who were all actively engaged in the same profession, trade, or occupation and the association has been maintained in good faith for purposes other than obtaining coverage unless waived by the commissioner.

(*iii*) Subject to section 421(2), an association or to a trust or to the trustees of a fund established, created, or maintained for the benefit of members of 1 or more associations.

(*iv*) A group other than that described in subparagraphs (*i*), (*ii*), or (*iii*) if the commissioner determines all of the following:

(A) The issuance of the group certificate is not contrary to the best interests of the public.

(B) The issuance of the group certificate would result in economies of acquisition or administration.

(C) The benefits are reasonable in relation to the premiums charged.

(c) "Home care services" means 1 or more of the following medically prescribed services or assessment team recommended services for the long-term care and treatment of a member that are to be provided by 1 or more home health or care agencies in a noninstitutional setting according to a written diagnosis and plan of care or individual assessment and plan of care:

(*i*) Nursing services under the direction of a registered nurse, including the service of a home health aide.

(*ii*) Physical therapy.

(*iii*) Speech therapy.

(*iv*) Respiratory therapy.

(*v*) Occupational therapy.

(*vi*) Nutritional services provided by a registered dietitian.

(*vii*) Personal care services, homemaker services, adult day care, and similar nonmedical services.

(*viii*) Medical social services.

(*ix*) Other similar medical services and health-related support services.

(d) "Home health or care agency" means a person certified by medicare whose business is to provide to

individuals in their places of residence other than in a hospital, nursing home, or county medical care facility, 1 or more of the following services: nursing services, therapeutic services, social work services, homemaker services, home health aide services, or other related services.

(e) "Intermediate care facility" means a facility, or distinct part of a facility, certified by the department of public health to provide intermediate care, custodial care, or basic care that is less than skilled nursing care but more than room and board.

(f) "Long-term care coverage" means an individual or group certificate or rider advertised, marketed, offered, or designed to provide coverage for at least 12 consecutive months for each covered person on an expense-incurred, indemnity, prepaid, or other basis for 1 or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, personal, or custodial care services provided in a setting other than an acute care unit of a hospital. Long-term care coverage does not include a certificate which is offered primarily to provide coverage for rehabilitative and convalescent care and is not offered, advertised, or marketed as a long-term care certificate, or that is offered primarily to provide basic medicare supplemental coverage, hospital confinement indemnity coverage, basic hospital expense coverage, basic medical surgical expense coverage, major medical expense coverage, disability income protection coverage, catastrophic coverage, comprehensive coverage, accident only coverage, specific disease or specified accident coverage, or limited benefit health coverage.

(g) "Preexisting condition" means a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services within 6 months preceding the effective date of coverage of a member.

(h) "Skilled nursing facility" means a facility, or a distinct part of a facility, certified by the department of public health to provide skilled nursing care.

History: Add. 1989, Act 110, Eff. Jan. 3, 1990.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1420a Long-term care coverage; offer through subsidiary.

Sec. 420a. A health care corporation shall only offer long-term care coverage through a subsidiary of the health care corporation. If a health care corporation subsidiary offers long-term care coverage in this state, the sale of that coverage is not exempt from taxation by this state or any political subdivision of this state.

History: Add. 2003, Act 58, Eff. July 15, 2003.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1421 Group long-term care certificate; requirements; satisfaction of organizational requirements.

Sec. 421. (1) Group long-term care coverage shall not be offered to a resident of this state under a group certificate issued in another state to a group described in section 420(b)(*iv*), unless the commissioner of this state has made a determination that those requirements have been met.

(2) Before advertising, marketing, or offering a group long-term care certificate within this state to a group described in section 420(b)(*iii*), the group or the corporation shall file evidence with the commissioner that the group meets all of the following requirements:

(a) Consists of at least 100 members.

(b) Has been in active existence for at least 1 year.

(c) Holds regular meetings at least annually.

(d) Except for credit unions, the group collects dues or solicits contributions from members.

(e) The members have voting privileges and representation on the governing board and committees.

(f) Has been organized and maintained in good faith for purposes other than obtaining coverage. The commissioner may waive the requirement provided in this subdivision.

(3) Thirty days after making the filing under this section, the group described in section 420(b)(*iii*) shall be considered to satisfy such organizational requirements, unless the commissioner makes a finding that the group does not satisfy those organizational requirements.

History: Add. 1989, Act 110, Eff. Jan. 3, 1990.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1422 Rules.

Sec. 422. The commissioner may promulgate rules including the following:

Rules establishing standards for the sale of long-term care certificates; terms of renewability; initial and subsequent conditions of eligibility; nonduplication of coverage provisions; coverage of dependents if provided in the certificate; preexisting conditions; termination of coverage; continuation or conversion; probationary periods; limitations; exceptions; reductions; elimination periods; requirements for replacement; recurrent conditions; definitions of terms; and for full and fair disclosure setting forth the manner, content, and required disclosures.

History: Add. 1989, Act 110, Eff. Jan. 3, 1990.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1422a Long-term care coverage; application.

Sec. 422a. A health care corporation subsidiary may use an application form for long-term care coverage that is designed to elicit the complete health history of an applicant.

History: Add. 2003, Act 58, Eff. July 15, 2003.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1422b Rate differential; basis.

Sec. 422b. A health care corporation subsidiary may charge a different rate based on age for the same long-term care coverage if the rate differential is based on sound actuarial principles and a reasonable classification system and is related to actual and credible loss statistics or, for new coverages, is related to reasonably anticipated experience.

History: Add. 2003, Act 58, Eff. July 15, 2003.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1422c Long-term care coverage.

Sec. 422c. A health care corporation subsidiary may condition the granting of long-term care coverage based on answers given on an application under section 422a and pursuant to underwriting standards established by the subsidiary of the corporation.

History: Add. 2003, Act 59, Eff. July 23, 2003.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1423 Individual long-term care certificate; guaranteed renewable provision; prohibited grounds for cancelation or termination; conversion provision; limitation period; home care services; hospitalization or institutionalization within 30 days of application for long-term care coverage.

Sec. 423. (1) Each individual long-term care certificate shall contain a guaranteed renewable provision. A health care corporation shall not cancel or otherwise terminate a long-term care certificate on the grounds of the age or the deterioration of the mental or physical health of the member.

(2) Each group long-term care certificate shall contain a conversion provision permitting an individual entitled to benefits under the group certificate to elect to convert from the group certificate to an individual long-term care certificate with the option of receiving benefits substantially similar to the prior coverage.

(3) If existing coverage is converted to or replaced by a long-term care certificate with the same health care corporation, the long-term care certificate shall not contain a provision establishing a new limitation period except with respect to an increase in benefits voluntarily selected by the member.

(4) A long-term care certificate that provides coverage for care in an intermediate care facility or a skilled nursing facility shall also provide coverage for home care services.

(5) Notwithstanding any other provision of this act, if a health care corporation established, maintained, or operating in this state offers long-term care coverage, it is not required to offer long-term care coverage to a state resident who is hospitalized or institutionalized, or who has been informed by a physician that he or she will require hospitalization or institutionalization within 30 days after the time of application for long-term care coverage, until the day after the date of discharge from the facility.

History: Add. 1989, Act 110, Eff. Jan. 3, 1990.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1424 Preexisting condition limitation period; limitation; definition of preexisting condition; health history; coverage of preexisting condition; excluding, limiting, or reducing coverage or benefits.

Sec. 424. (1) A preexisting condition limitation period in a long-term care certificate, other than a group long-term care certificate described in section 420(b)(*i*), shall not exceed 1 of the following:

(a) Six months after the effective date of coverage.

(b) A period of time set by the commissioner if the commissioner has found that a longer limitation period than provided for in subdivision (a) is justified because the group is specially limited by age, group categories, or other specific certificate provisions and that the longer limitation period will be in the best interest of the public.

(2) A long-term care certificate, other than a group long-term care certificate described in section 420(b)(*i*), shall not use a definition of preexisting condition which is more restrictive than the definition in section 420.

(3) The definition of preexisting condition does not prohibit a health care corporation from using an application form designed to elicit the complete health history of an applicant.

(4) Unless otherwise provided in the certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until after the limitation period. A long-term care certificate shall not exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting conditions beyond the limitation period.

History: Add. 1989, Act 110, Eff. Jan. 3, 1990.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1425 Conditioning benefits; prohibition.

Sec. 425. A long-term care insurance certificate shall not condition benefits on the prior institutionalization of the member.

History: Add. 1989, Act 110, Eff. Jan. 3, 1990.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1426 Return of certificate and refund of premium; notice; outline of coverage; definition.

Sec. 426. (1) Except as otherwise provided in subsection (2), individual long-term care subscribers shall have the right to return the certificate within 30 days after its delivery and to have the entire premium refunded if, after examination of the certificate, the subscriber is not satisfied for any reason and benefits have not been incurred under the certificate. Long-term care certificates shall have a notice prominently printed on the first page of the certificate and the outline of coverage stating in substance that the subscriber shall have the right to return the certificate within 30 days after its delivery and to have the entire premium refunded if, after examination of the certificate, the subscriber is not satisfied for any reason.

(2) A subscriber covered under a long-term care certificate issued pursuant to a direct response solicitation shall have the right to return the certificate within 30 days after its delivery and to have the entire premium refunded if, after examination, the subscriber is not satisfied for any reason. Long-term care certificates issued pursuant to a direct response solicitation shall have a notice prominently printed on the first page of the certificate and the outline of coverage stating in substance that the subscriber shall have the right to return the certificate within 30 days after its delivery and to have the entire premium refunded if, after examination, the subscriber is not satisfied for any reason. As used in this section, "direct response solicitation" means solicitation in which a representative of the health care corporation does not contact the applicant in person and explain the coverage available, such as, but not limited to, solicitation through direct mail or through advertisements in periodicals and other media.

History: Add. 1989, Act 110, Eff. Jan. 3, 1990.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1427 Summary of benefits.

Sec. 427. A health care corporation that offers nongroup long-term care coverage shall provide to a prospective applicant before application, and upon request before renewal, a summary of benefits and shall obtain an acknowledgment of receipt of the summary on the application form or renewal form by obtaining the signature of the applicant. A health care corporation using direct sales response shall provide the summary of benefits to an

applicant in conjunction with the initial application and upon request before renewal. The summary of benefits shall be in substantially the following form:

LONG-TERM CARE CERTIFICATE SUMMARY OF BENEFITS

Category	Definition	Company Benefits
Skilled nursing care	Requires daily attendance, monitoring, evaluation and/or observation by licensed health personnel in a licensed skilled nursing care facility	$_____ per day
Maximum days payable		___ days
Intermediate/basic/custodial nursing care	Is care that includes assistance in activities of daily living that can be provided by persons without medical skill in a licensed intermediate or skilled nursing care facility	$_____ per day
Maximum days payable		___ days
Home health benefits: —Daily benefit —Maximum days payable —Restrictions	Will this certificate cover home care and what are the restrictions?	___Yes ___No $___ per day ___ No. of days
Prior hospitalization	Certificates may not require that you be placed in a hospital for a certain number of days before you can receive coverage for nursing home care	
Day benefits begin	After you have entered the nursing home, when will the certificate start to pay for coverage?	
Preexisting conditions waiting period	If you have been treated in the last 6 months for a condition, will this certificate cover your treatment?	___Yes ___No
	Does this certificate cover you only after a waiting period?	___Yes ___No
	How long is the waiting period?	_____
Prior approval for coverage	Is prior approval needed before your certificate will give you coverage?	___Yes ___No
Motor vehicle accidents	Will this certificate provide coverage for long-term care needed as a result of a motor vehicle accident?	___Yes ___No

Evidence of insurability	Is a physical examination required?	___Yes ___No
	Do you have to answer a series of health questions?	___Yes ___No
Guaranteed renewal	As long as you pay your premiums on time, will the corporation continue to cover you?	___Yes ___No
Waiver of premium	Are there circumstances under which you receive coverage, but do not have to pay the premium?	___Yes ___No

I have read this summary and understand that this summary is for my own use and is mine to keep.

_____

Prospective Applicant's Signature

Date_____

History: Add. 1989, Act 305, Imd. Eff. Jan. 3, 1990.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1428 Application for long-term care certificate; statement.

Sec. 428. An application for a long-term care certificate shall contain the following statement printed, stamped, or as part of a sticker permanently affixed to the application in capital letters on the first page:

"For additional information about long-term care coverage write to the Michigan insurance bureau, P.O. Box 30220, Lansing, MI 48909 or call the area agency on aging in your community."

History: Add. 1989, Act 305, Imd. Eff. Jan. 3, 1990.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1429 Long-term care coverage; requirements.

Sec. 429. (1) Long-term care coverage shall meet all of the following requirements:

(a) Shall include coverage for intermediate/basic care.

(b) Shall not limit or exclude coverage by type of illness, treatment, medical condition, or accident other than a motor vehicle accident, except as follows:

(*i*) Preexisting conditions.

(*ii*) Mental or nervous disorders; however, this shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder and shall not permit exclusion or limitation of benefits on the basis of Alzheimer's disease or related disorders.

(*iii*) Alcoholism or drug addiction.

(*iv*) Illness, treatment, or medical condition arising out of any of the following:

(A) War or act of war, whether declared or undeclared.

(B) Participation in a felony, riot, or insurrection.

(C) Service in the armed forces or units auxiliary to the armed forces.

(D) Suicide, whether the individual was sane or insane at the time of the suicide, attempted suicide, or intentionally self-inflicted injury.

(*v*) This subdivision is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

(2) Long-term care coverage other than home care coverage may provide that before certain coverages in the certificate take effect, care must first be recommended by a person or persons as provided in the certificate and

approved by the commissioner or prescribed by a licensed treating physician. Long-term care coverage for home care may provide that before coverage for home care in the certificate takes effect, care must first be prescribed or recommended by a person or persons as provided in the certificate and approved by the commissioner.

History: Add. 1989, Act 305, Imd. Eff. Jan. 3, 1990;—Am. 1990, Act 92, Imd. Eff. June 1, 1990.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1430 Compliance.

Sec. 430. Each certificate that is advertised, marketed, or offered as long-term care coverage or nursing home coverage shall comply with sections 420 to 429 and the other applicable provisions of this act. A certificate that is not advertised, marketed, or offered using the name long-term care coverage or nursing home coverage need not comply with sections 420 to 429.

History: Add. 1989, Act 110, Eff. Jan. 3, 1989;—Am. 1989, Act 305, Imd. Eff. Jan. 3, 1990.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1435 "Program" defined.

Sec. 435. As used in sections 436 to 439, "program" means the Michigan caring program created in section 436.

History: Add. 1991, Act 60, Imd. Eff. June 27, 1991.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1436 Michigan caring programs for children; creation; contribution requirements; rating methodologies; supersedure of inconsistent provisions.

Sec. 436. There may be created within each health care corporation a Michigan caring program for children. The program shall provide primary health care coverage for children as set forth in section 438 and shall be administered by the health care corporation. Each program shall be described in a certificate that sets forth the benefits provided. A certificate and the contribution to be charged shall be subject to the commissioner's approval. Contribution requirements shall be established in accordance with rating methodologies approved by the commissioner which, over time, shall not result in either gain or loss to the corporation. The rating methodology for a program shall not include any factors otherwise includable pursuant to other sections of this act that are intended to provide for subsidies, surcharges, or administrative costs. Any other provisions of this act that would otherwise apply to a program but which are inconsistent with the provisions of this section and sections 437 to 439 are superseded.

History: Add. 1991, Act 60, Imd. Eff. June 27, 1991.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1437 Eligibility of child for enrollment in program.

Sec. 437. A child is eligible for enrollment in the program if the child meets all of the following:

(a) Is less than 19 years of age.

(b) Is unmarried.

(c) Resides in a household with income 185% or less of the federal poverty level.

(d) Is ineligible to receive health care through title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396d, 1396f to 1369g, and 1396i to 1396s.

(e) Is enrolled in the program with all other eligible siblings who have no other health care coverage available.

(f) Is a resident of this state.

(g) Has no other health care coverage available.

History: Add. 1991, Act 60, Imd. Eff. June 27, 1991.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1438 Limitation of benefits; provision of other health care benefits.

Sec. 438. (1) Notwithstanding any other provision of this act, a health care corporation may limit the benefits it will furnish to an eligible child enrolled in the program to the following primary health care benefits:

(a) Doctor office visits for a sick child.

(b) Medically necessary outpatient diagnostic tests.

(c) Emergency medical and accident care in a doctor's office or hospital's emergency room.

(d) Medically necessary outpatient surgery and anesthesia.

(e) Preventive care, including, but not limited to, immunizations and well-child visits to a doctor's office.

(f) Outpatient substance abuse care.

(2) With the commissioner's approval, a health care corporation may provide other health care benefits in addition to the primary health care benefits set forth in subsection (1).

History: Add. 1991, Act 60, Imd. Eff. June 27, 1991.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1439 Fees prohibited; exception; funding; enrollment of children.

Sec. 439. The program shall not charge any fee to an enrolled eligible child or the child's parents or legal guardians except that if prescription drug benefits are offered a co-pay not to exceed $3.00 may be charged. The program shall be funded by private donations and private and public grants. The health care corporation may provide free of charge administrative services to the program as approved by its board of directors and subject to the commissioner's approval. A child shall be enrolled as follows:

(a) Dependent on funding on a first-come, first-served basis unless a named child is part of a group of 10 or more children who are fully sponsored by private donations.

(b) Without regard to health status.

History: Add. 1991, Act 60, Imd. Eff. June 27, 1991.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

PART 4A
MEDICARE SUPPLEMENT CERTIFICATES

550.1451 Definitions.

Sec. 451. As used in this part:

(a) "Applicant" means:

(*i*) For a nongroup medicare supplement certificate, the person who seeks to contract for benefits.

(*ii*) For a group medicare supplement certificate, the proposed certificate holder.

(b) "Bankruptcy" means when a medicare+choice organization that is not an insurer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in this state.

(c) "Certificate" means any certificate delivered or issued for delivery in this state under a medicare supplement certificate.

(d) "Certificate form" means the form on which the certificate is delivered or issued for delivery.

(e) "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than 63 days.

(f) "Creditable coverage" means coverage of an individual provided under any of the following:

(*i*) A group health plan.

(*ii*) Health insurance coverage.

(*iii*) Part A or part B of medicare.

(*iv*) Medicaid other than coverage consisting solely of benefits under section 1928 of medicaid, 42 U.S.C. 1396s.

(*v*) Chapter 55 of title 10 of the United States Code, 10 U.S.C. 1071 to 1110.

(*vi*) A medical care program of the Indian health service or of a tribal organization.

(*vii*) A state health benefits risk pool.

(*viii*) A health plan offered under chapter 89 of title 5 of the United States Code, 5 U.S.C. 8901 to 8914.

(*ix*) A public health plan as defined in federal regulation.

(*x*) Health care under section 5(e) of title I of the peace corps act, Public Law 87-293, 22 U.S.C. 2504.

(g) "Direct response solicitation" means solicitation in which a health care corporation representative does not contact the applicant in person and explain the coverage available, such as, but not limited to, solicitation through direct mail or through advertisements in periodicals and other media.

(h) "Employee welfare benefit plan" means a plan, fund, or program of employee benefits as defined in section 3 of subtitle A of title I of the employee retirement income security act of 1974, Public Law 93-406, 29 U.S.C. 1002.

(i) "Insolvency" means when an insurer licensed to transact the business of insurance in this state has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the insurer's state of domicile.

(j) "Insurer" includes any entity, including a health care corporation, delivering or issuing for delivery in this state medicare supplement policies.

(k) "Medicaid" means title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396r-6 and 1396r-8 to 1396v.

(*l*) "Medicare" means title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395 to 1395b, 1395b-2, 1395b-6 to 1395b-7, 1395c to 1395i, 1395i-2 to 1395i-5, 1395j to 1395t, 1395u to 1395w, 1395w-2 to 1395w-4, 1395w-21 to 1395w-28, 1395x to 1395yy, and 1395bbb to 1395ggg.

(m) "Medicare+choice plan" means a plan of coverage for health benefits under medicare part C as defined in section 1859 of part C of medicare, 42 U.S.C. 1395w-28, and includes any of the following:

(*i*) Coordinated care plans that provide health care services, including, but not limited to, health maintenance organization plans with or without a point-of-service option, plans offered by provider-sponsored organizations, and preferred provider organization plans.

(*ii*) Medical savings account plans coupled with a contribution into a medicare+choice medical savings account.

(*iii*) Medicare+choice private fee-for-service plans.

(n) "Medicare supplement buyer's guide" means the document entitled, "guide to health insurance for people with medicare", developed by the national association of insurance commissioners and the United States department of health and human services or a substantially similar document as approved by the commissioner.

(o) "Medicare supplement certificate" means a nongroup or group certificate that is advertised, marketed, or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare and medicare select certificates under section 467. Medicare supplement certificate does not include a certificate of 1 or more employers or labor organizations, or of the trustees of a fund established by 1 or more employers or labor organizations, or both, for employees or former employees, or both, or for members or former members, or both, of the labor organizations.

(p) "PACE" means a program of all-inclusive care for the elderly as described in the social security act.

(q) "Secretary" means the secretary of the United States department of health and human services.

(r) "Social security act" means the social security act, chapter 531, 49 Stat. 620.

History: Add. 1994, Act 40, Imd. Eff. Mar. 14, 1994;—Am. 2002, Act 559, Imd. Eff. Sept. 27, 2002.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1452 Applicability.

Sec. 452. (1) Except as provided in subsection (2), this part applies to a medicare supplement certificate delivered, issued for delivery, or renewed in this state on or after the effective date of this part.

(2) Sections 459, 461, and 469(1) do not apply to a medicare supplement certificate issued before the effective date of this part.

History: Add. 1994, Act 40, Imd. Eff. Mar. 14, 1994.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1453 Medicare supplement certificate; definitions.

Sec. 453. As used in a medicare supplement certificate:

(a) The definition of "accident", "accidental injury", or "accidental means" shall not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization. The definition may provide that injuries shall not include injuries for which benefits are provided or available under any worker's compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

(b) The definition of "benefit period" or "medicare benefit period" shall not be defined in a more restrictive manner than as defined in medicare.

(c) "Hospital" may be defined in relation to its status, facilities, and available services or to reflect its accreditation by the joint commission on accreditation of hospitals, but not more restrictively than as defined in

medicare.

(d) The definition of "medicare eligible expenses" shall mean health care expenses of the kinds covered by medicare, to the extent recognized as reasonable and medically necessary by medicare.

(e) "Nurses" may be defined so that the description of nurse is to a type of nurse, such as a registered professional nurse or a licensed practical nurse. If the words "nurse", "trained nurse", or "registered nurse" are used without specific instruction, then the use of those terms requires the health care corporation to recognize the services of any individual who qualifies under those terms in accordance with the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.1101 to 333.25211 of the Michigan Compiled Laws.

(f) "Physician" shall not be defined more restrictively than as defined in medicare.

(g) "Sickness" shall not be defined more restrictively than to mean illness or disease of a covered person that first manifests itself after the effective date of coverage and while the coverage is in force. The definition may be further modified to exclude sicknesses or diseases for which benefits are provided to the member under any worker's compensation, occupational disease, employer's liability, or similar law.

(h) "Skilled nursing facility" shall not be defined more restrictively than as defined in medicare.

History: Add. 1994, Act 40, Imd. Eff. Mar. 14, 1994.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1455 Basic core package of benefits; additional benefits; availability; contents.

Sec. 455. Every health care corporation issuing a medicare supplement certificate in this state shall make available a medicare supplement certificate that includes only a basic core package of benefits to each prospective member. A health care corporation issuing a medicare supplement certificate in this state may make available to prospective members benefits pursuant to section 459 that are in addition to, but not instead of, the basic core package. The basic core package of benefits shall include all of the following:

(a) Coverage of part A medicare eligible expenses for hospitalization to the extent not covered by medicare from the 61st day through the 90th day in any medicare benefit period.

(b) Coverage of part A medicare eligible expenses incurred for hospitalization to the extent not covered by medicare for each medicare lifetime inpatient reserve day used.

(c) Upon exhaustion of the medicare hospital inpatient coverage including the lifetime reserve days, coverage of the medicare part A eligible expenses for hospitalization paid at the diagnostic related group day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days.

(d) Coverage under medicare parts A and B for the reasonable cost of the first 3 pints of blood or equivalent quantities of packed red blood cells, as defined under federal regulations unless replaced in accordance with federal regulations.

(e) Coverage for the coinsurance amount, or the copayment amount paid for hospital outpatient department services under a prospective payment system, of medicare eligible expenses under part B regardless of hospital confinement, subject to the medicare part B deductible.

History: Add. 1994, Act 40, Imd. Eff. Mar. 14, 1994;—Am. 2002, Act 559, Imd. Eff. Sept. 27, 2002.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1457 Availability of benefits provided in § 550.1461(5)(c).

Sec. 457. Every health care corporation issuing a medicare supplement certificate in this state shall make available a medicare supplement certificate that includes the benefits provided in section 461(5)(c).

History: Add. 1994, Act 40, Imd. Eff. Mar. 14, 1994.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1459 Benefits in addition to basic core package; conformance to § 550.1461(5)(b) to (j); reimbursement for preventative screening tests and services; definitions.

Sec. 459. (1) In addition to the basic core package of benefits required under section 455, the following benefits may be included in a medicare supplement certificate and if included shall conform to section 461(5)(b) to (j):

(a) Medicare part A deductible: coverage for all of the medicare part A inpatient hospital deductible amount per benefit period.

(b) Skilled nursing facility care: coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a medicare benefit period for posthospital skilled nursing facility care eligible

under medicare part A.

(c) Medicare part B deductible: coverage for all of the medicare part B deductible amount per calendar year regardless of hospital confinement.

(d) Eighty percent of the medicare part B excess charges: coverage for 80% of the difference between the actual medicare part B charge as billed, not to exceed any charge limitation established by medicare or state law, and the medicare-approved part B charge.

(e) One hundred percent of the medicare part B excess charges: coverage for all of the difference between the actual medicare part B charge as billed, not to exceed any charge limitation established by medicare or state law, and the medicare-approved part B charge.

(f) Basic outpatient prescription drug benefit: coverage for 50% of outpatient prescription drug charges, after a $250.00 calendar year deductible, to a maximum of $1,250.00 in benefits received by the member per calendar year, to the extent not covered by medicare.

(g) Extended outpatient prescription drug benefit: coverage for 50% of outpatient prescription drug charges, after a $250.00 calendar year deductible, to a maximum of $3,000.00 in benefits received by the member per calendar year, to the extent not covered by medicare.

(h) Medically necessary emergency care in a foreign country: coverage to the extent not covered by medicare for 80% of the billed charges for medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250.00, and a lifetime maximum benefit of $50,000.00. For purposes of this benefit, “emergency care” means care needed immediately because of an injury or an illness of sudden and unexpected onset.

(i) Preventive medical care benefit: coverage for the following preventive health services:

(*i*) An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph (*ii*) and patient education to address preventive health care measures.

(*ii*) Any 1 or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(A) Digital rectal examination.

(B) Dipstick urinalysis for hematuria, bacteriuria, and proteinuria.

(C) Pure tone, air only, hearing screening test, administered or ordered by a physician.

(D) Serum cholesterol screening every 5 years.

(E) Thyroid function test.

(F) Diabetes screening.

(G) Tetanus and diphtheria booster every 10 years.

(H) Any other tests or preventive measures determined appropriate by the attending physician.

(j) At-home recovery benefit: coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery. At-home recovery services provided shall be primarily services that assist in activities of daily living. The member's attending physician shall certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by medicare. Coverage is excluded for home care visits paid for by medicare or other government programs and care provided by family members, unpaid volunteers, or providers who are not care providers. Coverage is limited to:

(*i*) No more than the number of at-home recovery visits certified as necessary by the member's attending physician. The total number of at-home recovery visits shall not exceed the number of medicare approved home health care visits under a medicare approved home care plan of treatment.

(*ii*) The actual charges for each visit up to a maximum reimbursement of $40.00 per visit.

(*iii*) One thousand six hundred dollars per calendar year.

(*iv*) Seven visits in any 1 week.

(*v*) Care furnished on a visiting basis in the member's home.

(*vi*) Services provided by a care provider as defined in this section.

(*vii*) At-home recovery visits while the member is covered under the certificate and not otherwise excluded.

(*viii*) At-home recovery visits received during the period the member is receiving medicare approved home care services or no more than 8 weeks after the service date of the last medicare approved home health care visit.

(k) New or innovative benefits: a health care corporation may, with the prior approval of the commissioner, offer new or innovative benefits in addition to the benefits provided in a certificate that otherwise complies with the

applicable standards. These benefits may include benefits that are appropriate to medicare supplement coverage, new or innovative, not otherwise available, cost-effective, and offered in a manner that is consistent with the goal of simplification of medicare supplement certificates.

(2) Reimbursement for the preventive screening tests and services under subsection (1)(i)(*ii*) shall be for the actual charges up to 100% of the medicare-approved amount for each test or service, as if medicare were to cover the test or service as identified in the American medical association current procedural terminology codes, to a maximum of $120.00 annually under this benefit. This benefit shall not include payment for any procedure covered by medicare.

(3) As used in subsection (1)(j):

(a) "Activities of daily living" include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(b) "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(c) "Home" means any place used by the member as a place of residence, provided that it qualifies as a residence for home health care services covered by medicare. A hospital or skilled nursing facility shall not be considered the member's home.

(d) "At-home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive 4 hours in a 24-hour period of services provided by a care provider is 1 visit.

History: Add. 1994, Act 40, Imd. Eff. Mar. 14, 1994;—Am. 2002, Act 559, Imd. Eff. Sept. 27, 2002.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1461 Availability of certificate form containing basic core benefits; other groups, packages, or combinations of benefits; designations; structure, language, and format; use of other designations; requirements.

Sec. 461. (1) A health care corporation shall make available to each prospective medicare supplement certificate holder a certificate form containing only the basic core benefits as provided in section 455.

(2) Groups, packages, or combinations of medicare supplement benefits other than those listed in this section shall not be offered for sale in this state except as may be permitted in section 459(1)(k).

(3) Benefit plans shall contain the appropriate a through j designations, shall be uniform in structure, language, and format to the standard benefit plans in subsection (5), and shall conform to the definitions in this part. Each benefit shall be structured in accordance with sections 455 and 459 and list the benefits in the order shown in subsection (5). For purposes of this section, "structure, language, and format" means style, arrangement, and overall content of a benefit.

(4) In addition to the benefit plan designations a through j as provided under subsection (5), a health care corporation may use other designations to the extent permitted by law.

(5) A medicare supplement benefit plan shall conform to 1 of the following:

(a) A standardized medicare supplement benefit plan A shall be limited to the basic core benefits common to all benefit plans as defined in section 455.

(b) A standardized medicare supplement benefit plan B shall include only the following: the core benefits as defined in section 455 and the medicare part A deductible as defined in section 459(1)(a).

(c) A standardized medicare supplement benefit plan C shall include only the following: the core benefits as defined in section 455, the medicare part A deductible, skilled nursing facility care, medicare part B deductible, and medically necessary emergency care in a foreign country as defined in section 459(1)(a), (b), (c), and (h).

(d) A standardized medicare supplement benefit plan D shall include only the following: the core benefits as defined in section 455, the medicare part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in section 459(1)(a), (b), (h), and (j).

(e) A standardized medicare supplement benefit plan E shall include only the following: the core benefits as defined in section 455, the medicare part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and preventive medical care as defined in section 459(1)(a), (b), (h), and (i).

(f) A standardized medicare supplement benefit plan F shall include only the following: the core benefits as defined in section 455, the medicare part A deductible, skilled nursing facility care, medicare part B deductible,

100% of the medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in section 459(1)(a), (b), (c), (e), and (h). A standardized medicare supplement plan F high deductible shall include only the following: 100% of covered expenses following the payment of the annual high deductible plan F deductible. The covered expenses include the core benefits as defined in section 455, plus the medicare part A deductible, skilled nursing facility care, the medicare part B deductible, 100% of the medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in section 459(1)(a), (b), (c), (e), and (h). The annual high deductible plan F deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the medicare supplement plan F certificate, and shall be in addition to any other specific benefit deductibles. The annual high deductible plan F deductible is $1,580.00 for calendar year 2001, and the secretary shall adjust it annually thereafter to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, rounded to the nearest multiple of $10.00.

(g) A standardized medicare supplement benefit plan G shall include only the following: the core benefits as defined in section 455, the medicare part A deductible, skilled nursing facility care, 80% of the medicare part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in section 459(1)(a), (b), (d), (h), and (j).

(h) A standardized medicare supplement benefit plan H shall include only the following: the core benefits as defined in section 455, the medicare part A deductible, skilled nursing facility care, basic outpatient prescription drug benefit, and medically necessary emergency care in a foreign country as defined in section 459(1)(a), (b), (f), and (h).

(i) A standardized medicare supplement benefit plan I shall include only the following: the core benefits as defined in section 455, the medicare part A deductible, skilled nursing facility care, 100% of the medicare part B excess charges, basic outpatient prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefit as defined in section 459(1)(a), (b), (e), (f), (h), and (j).

(j) A standardized medicare supplement benefit plan J shall include only the following: the core benefits as defined in section 455, the medicare part A deductible, skilled nursing facility care, medicare part B deductible, 100% of the medicare part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit as defined in section 459(1)(a), (b), (c), (e), (g), (h), (i), and (j). A standardized medicare supplement benefit plan J high deductible plan shall consist of only the following: 100% of covered expenses following the payment of the annual high deductible plan J deductible. The covered expenses include the core benefits as defined in section 455, plus the medicare part A deductible, skilled nursing facility care, medicare part B deductible, 100% of the medicare part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in section 459(1)(a), (b), (c), (e), (g), (h), (i), and (j). The annual high deductible plan J deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the medicare supplement plan J certificate, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be $1,580.00 for calendar year 2001, and the secretary shall adjust it annually thereafter to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, rounded to the nearest multiple of $10.00.

History: Add. 1994, Act 40, Imd. Eff. Mar. 14, 1994;—Am. 2002, Act 559, Imd. Eff. Sept. 27, 2002.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1463 Certificate providing disability coverage; medicare supplement buyer's guide; acknowledgment of receipt.

Sec. 463. A health care corporation that issues a certificate that provides disability coverage to a person eligible for medicare by reason of age shall provide the prospective certificate holder with a medicare supplement buyer's guide, which shall be furnished at the time of application, and acknowledgment of receipt of the buyer's guide shall be obtained by the health care corporation. However, for direct response solicitation certificates, the guide shall be furnished with the certificate and acknowledgment of receipt need not be obtained by the health care corporation.

History: Add. 1994, Act 40, Imd. Eff. Mar. 14, 1994.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1465 Outline of coverage.

Sec. 465. (1) A health care corporation that offers a medicare supplement certificate shall provide an outline of

coverage to the applicant at the time of application and, except for direct response solicitation certificates, shall obtain an acknowledgment of receipt of the outline of coverage from the applicant. The outline of coverage provided to applicants pursuant to this section shall consist of the following 4 parts:

(a) A cover page.

(b) Premium information.

(c) Disclosure pages.

(d) Charts displaying the features of each benefit plan offered by the health care corporation.

(2) If an outline of coverage is provided at the time of application and the medicare supplement certificate is issued on a basis that would require revision of the outline, a substitute outline of coverage properly describing the certificate shall be delivered with the certificate and contain the following statement, in no less than 12-point type, immediately above the company name:

NOTICE: READ THIS OUTLINE OF COVERAGE CAREFULLY. IT IS NOT IDENTICAL TO THE OUTLINE OF COVERAGE PROVIDED UPON APPLICATION AND THE COVERAGE ORIGINALLY APPLIED FOR HAS NOT BEEN ISSUED.

(3) An outline of coverage under subsection (1) shall be in the language and format prescribed in this section and in not less than 12-point type. The A through J letter designation of the plan shall be shown on the cover page and the plans offered by the health care corporation shall be prominently identified. Premium information shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and method of payment shall be stated for all plans that are offered to the applicant. All possible premiums for the applicant shall be illustrated. The following items shall be included in the outline of coverage in the order prescribed below and in substantially the following form, as approved by the commissioner:

(Health Care Corporation Name)

Medicare Supplement Coverage

Outline of Medicare Supplement Coverage-Cover Page:

Benefit Plan(s) _____ [insert letter(s) of plan(s) being offered]

Medicare supplement coverage can be sold in only 10 standard plans plus 2 high deductible plans. This chart shows the benefits included in each plan. Every health care corporation shall make available Plan “A”. Some plans may not be available in your state.

BASIC BENEFITS: Included in All Plans.

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (20% of Medicare-approved expenses) or, for hospital outpatient department services under a prospective payment system, applicable copayments.

Blood: First three pints of blood each year.

	A	B	C	D	E	F	G	H	I	J
Basic Benefits	x	x	x	x	x	x	x	x	x	x
Skilled Nursing Co-Insurance			x	x	x	x	x	x	x	x
Part A Deductible		x	x	x	x	x	x	x	x	x
Part B Deductible			x			x				x
Part B Excess						x 100%	x 80%		x 100%	x 100%
Foreign Travel Emergency			x	x	x	x	x	x	x	x
At-Home Recovery				x			x		x	x

Drugs		x $1,250 Limit	x $1,250 Limit	x $3,000 Limit
Preventive Care	x			x

PREMIUM INFORMATION

We (insert health care corporation's name) can only raise your premium if we raise the premium for all certificates like yours in this state. (If the premium is based on the increasing age of the member, include information specifying when premiums will change).

DISCLOSURES

Use this outline to compare benefits and premiums among policies, certificates, and contracts.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your certificate's most important features. The certificate is your contract. You must read the certificate itself to understand all of the rights and duties of both you and your health care corporation.

RIGHT TO RETURN CERTIFICATE

If you find that you are not satisfied with your certificate, you may return it to (insert health care corporation's address). If you send the certificate back to us within 30 days after you receive it, we will treat the certificate as if it had never been issued and return all of your payments.

CERTIFICATE REPLACEMENT

If you are replacing another health insurance policy, contract, or certificate, do not cancel it until you have actually received your new certificate and are sure you want to keep it.

NOTICE

This certificate may not fully cover all of your medical costs.

[For agent issued certificates]

Neither (insert health care corporation's name) nor its agents are connected with medicare.

[For direct response issued certificates]

(Insert health care corporation's name) is not connected with medicare.

This outline of coverage does not give all the details of medicare coverage. Contact your local social security office or consult “the medicare handbook” for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new certificate, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your certificate and refuse to pay any claims if you leave out or falsify important medical information. [If the certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan offered by the health care corporation a chart showing the services, medicare payments, plan payments, and member payments using the same language, in the same order, and using uniform layout and format as shown in the charts that follow. A health care corporation may use additional benefit plan designations on these charts pursuant to section 461(4). Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner. The health care corporation issuing the certificate shall change the dollar amounts each year to reflect current figures. No more than 4 plans may be shown on 1 chart.] Charts for each plan are as follows:

******* TABLE MISSING *******

******* SEE PUBLIC ACT 559 OF 2002 *******

COMPILER'S NOTE: DUE TO LIMITATIONS OF CURRENT SOFTWARE CAPABILITIES, THE TABLE CONTAINING *MEDICARE BENEFITS, PLANS A THROUGH J*, CANNOT BE REPRODUCED HERE. PLEASE SEE ACT 559 OF 2002 AT www.mileg.org FOR THE TEXT OF THIS TABLE.

History: Add. 1994, Act 40, Imd. Eff. Mar. 14, 1994;—Am. 2002, Act 559, Imd. Eff. Sept. 27, 2002.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1467 Medicare select certificate.

Sec. 467. (1) This section applies to medicare select certificates.

(2) As used in this section:

(a) "Complaint" means any dissatisfaction expressed by an individual concerning a medicare select health care corporation or its network providers.

(b) "Grievance" means a dissatisfaction expressed in writing by an individual covered under a medicare select certificate with the administration, claims practices, or provision of services concerning a medicare select health care corporation or its network providers.

(c) "Medicare select health care corporation" means a health care corporation offering, or seeking to offer, a medicare select certificate.

(d) "Medicare select certificate" means a medicare supplement certificate that contains restricted network provisions.

(e) "Network provider" means a provider of health care, or a group of providers of health care, that has entered into a written agreement with the health care corporation to provide benefits under a medicare select certificate.

(f) "Restricted network provision" means any provision that conditions the payment of benefits, in whole or in part, on the use of network providers.

(g) "Service area" means the geographic area approved by the commissioner within which a health care corporation is authorized to offer a medicare select certificate.

(3) A certificate shall not be advertised as a medicare select certificate unless it meets the requirements of this section.

(4) The commissioner may authorize a health care corporation to offer a medicare select certificate, pursuant to this section and section 1882 of part C of title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395ss, if the commissioner finds that the health care corporation has satisfied all necessary requirements.

(5) A medicare select health care corporation shall not issue a medicare select certificate in this state until its plan of operation has been approved by the commissioner.

(6) A medicare select health care corporation shall file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

(a) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, as follows:

(*i*) That services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation, and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(*ii*) That the number of network providers in the service area is sufficient, with respect to current and expected certificate holders, either to deliver adequately all services that are subject to a restricted network provision or to make appropriate referrals.

(*iii*) That there are written agreements with network providers describing specific responsibilities.

(*iv*) That emergency care is available 24 hours per day and 7 days per week.

(*v*) That in the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting such providers from billing or otherwise seeking reimbursement from or recourse against any individual covered under a medicare select certificate. This subparagraph does not apply to supplemental charges or coinsurance amounts as stated in the medicare select certificate.

(b) A statement or map providing a clear description of the service area.

(c) A description of the grievance procedure to be used.

(d) A description of the quality assurance program, including all of the following:

(*i*) The formal organizational structure.

(*ii*) The written criteria for selection, retention, and removal of network providers.

(*iii*) The procedures for evaluating quality of care provided by network providers and the process to initiate corrective action if warranted.

(e) A list and description, by specialty, of the network providers.

(f) Copies of the written information proposed to be used by the health care corporation to comply with subsection (10).

(g) Any other information requested by the commissioner.

(7) A medicare select health care corporation shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing any changes. An updated list of network providers shall be filed with the commissioner at least quarterly. Changes shall be considered approved

by the commissioner after 30 days unless specifically disapproved.

(8) A medicare select certificate shall not restrict payment for covered services provided by nonnetwork providers if the services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury, or a condition and it is not reasonable to obtain such services through a network provider.

(9) A medicare select certificate shall provide payment for full coverage under the certificate for covered services that are not available through network providers.

(10) A medicare select health care corporation shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the medicare select certificate to each applicant. This disclosure shall include at least all of the following:

(a) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the medicare select certificate with other medicare supplement certificates offered by the health care corporation or offered by other health care corporations.

(b) A description, including address, phone number, and hours of operation, of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers.

(c) A description of the restricted network provisions, including payments for coinsurance and deductibles if providers other than network providers are utilized.

(d) A description of coverage for emergency and urgently needed care and other out-of-service area coverage.

(e) A description of limitations on referrals to restricted network providers and to other providers.

(f) A description of the certificate holder's rights to purchase any other medicare supplement certificate otherwise offered by the health care corporation.

(g) A description of the medicare select health care corporation's quality assurance program and grievance procedure.

(11) Prior to the sale of a medicare select certificate, a medicare select health care corporation shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to subsection (10) and that the applicant understands the restrictions of the medicare select certificate.

(12) A medicare select health care corporation shall have and use procedures for hearing complaints and resolving written grievances from subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures. The grievance procedure shall be described in the certificate and in the outline of coverage. At the time the certificate is issued, the health care corporation shall provide detailed information to the certificate holder describing how a grievance may be registered with the health care corporation. Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action. If a grievance is found to be valid, corrective action shall be taken promptly. All concerned parties shall be notified about the results of a grievance. The health care corporation shall report no later than each March 31 to the commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of those grievances.

(13) At the time of initial purchase, a medicare select health care corporation shall make available to each applicant for a medicare select certificate the opportunity to purchase any medicare supplement certificate otherwise offered by the health care corporation.

(14) At the request of an individual covered under a medicare select certificate, a medicare select health care corporation shall make available to the individual covered the opportunity to purchase a medicare supplement certificate offered by the health care corporation that has comparable or lesser benefits and that does not contain a restricted network provision. The health care corporation shall make the certificates available without requiring evidence of insurability after the medicare supplement certificate has been in force for 6 months. For the purposes of this subsection, a medicare supplement certificate shall be considered to have comparable or lesser benefits unless it contains 1 or more significant benefits not included in the medicare select certificate being replaced. For the purposes of this subsection, a significant benefit means coverage for the medicare part A deductible, coverage for outpatient prescription drugs, coverage for at-home recovery services, or coverage for part B excess charges.

(15) Medicare select certificates shall provide for continuation of coverage if the secretary of health and human services determines that medicare select certificates issued pursuant to this section should be discontinued due to either the failure of the medicare select program to be reauthorized under law or its substantial amendment. Each medicare select health care corporation shall make available to each member covered under a medicare select certificate the opportunity to purchase any medicare supplement certificate offered by the health care corporation that has comparable or lesser benefits and that does not contain a restricted network provision. The issuer shall make the certificates available without requiring evidence of insurability. For the purposes of this subsection, a

medicare supplement certificate will be considered to have comparable or lesser benefits unless it contains 1 or more significant benefits not included in the medicare select certificate being replaced. For the purposes of this subsection, a significant benefit means coverage for the medicare part A deductible, coverage for prescription drugs, coverage for at-home recovery service, or coverage for part B excess charges.

(16) A medicare select health care corporation shall comply with reasonable requests for data made by state or federal agencies, including the United States department of health and human services, for the purposes of evaluating the medicare select program.

History: Add. 1994, Act 40, Imd. Eff. Mar. 14, 1994.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1469 Medicare supplement certificate; minimum standards; notice of medical assistance under medicaid; suspension of benefits and premiums; reinstitution of certificate.

Sec. 469. (1) A certificate shall not be titled, advertised, solicited, or issued for delivery in this state as a medicare supplement certificate if the certificate does not meet the minimum standards prescribed in this section. These minimum standards are in addition to all other requirements of this part.

(2) The following standards apply to medicare supplement certificates:

(a) A medicare supplement certificate shall not deny a claim for losses incurred more than 6 months from the effective date of coverage because it involved a preexisting condition. The certificate shall not define a preexisting condition more restrictively than to mean a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.

(b) A medicare supplement certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(c) A medicare supplement certificate shall provide that benefits designed to cover cost sharing amounts under medicare will be changed automatically to coincide with any changes in the applicable medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

(d) A medicare supplement certificate shall be guaranteed renewable. Termination shall be for nonpayment of premium or material misrepresentation only.

(e) Termination of a medicare supplement certificate shall not reduce or limit the payment of benefits for any continuous loss that commenced while the certificate was in force, but the extension of benefits beyond the period during which the certificate was in force may be predicated upon the continuous total disability of the member, limited to the duration of the certificate benefit period, if any, or payment of the maximum benefits.

(f) A medicare supplement certificate shall not provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the member, other than the nonpayment of premium.

(3) A medicare supplement certificate shall provide that benefits and premiums under the certificate shall be suspended at the request of the certificate holder for a period not to exceed 24 months in which the certificate holder has applied for and is determined to be entitled to medical assistance under medicaid, but only if the certificate holder notifies the health care corporation of such assistance within 90 days after the date the individual becomes entitled to the assistance. Upon receipt of timely notice, the health care corporation shall return to the certificate holder that portion of the premium attributable to the period of medicaid eligibility, subject to adjustment for paid claims. If a suspension occurs and if the certificate holder loses entitlement to medical assistance under medicaid, the certificate shall be automatically reinstituted effective as of the date of termination of the assistance if the certificate holder provides notice of loss of medicaid medical assistance within 90 days after the date of the loss and pays the premium attributable to the period effective as of the date of termination of the assistance. Each medicare supplement certificate shall provide that benefits and premiums under the certificate shall be suspended at the request of the member if the member is entitled to benefits under section 226(b) of title II of the social security act, and is covered under a group health plan as defined in section 1862(b)(1)(A)(*v*) of the social security act. If suspension occurs and if the member loses coverage under the group health plan, the certificate shall be automatically reinstituted effective as of the date of loss of coverage if the member provides notice of loss of coverage within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan. All of the following apply to the reinstitution of a medicare supplement certificate under this subsection:

(*i*) The reinstitution shall not provide for any waiting period with respect to treatment of preexisting conditions.

(*ii*) Reinstituted coverage shall be substantially equivalent to coverage in effect before the date of the suspension.

(*iii*) Classification of premiums for reinstituted coverage shall be on terms at least as favorable to the certificate holder as the premium classification terms that would have applied to the certificate holder had the coverage not been suspended.

History: Add. 1994, Act 40, Imd. Eff. Mar. 14, 1994;—Am. 2002, Act 559, Imd. Eff. Sept. 27, 2002.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1471 Nongroup medicare supplement certificate; conditions requiring refund of premiums and interest; calculation of interest.

Sec. 471. (1) A health care corporation shall not issue a nongroup medicare supplement certificate to a person who has not applied for or enrolled in medicare, parts A and B. If it is later determined that a person has not applied for or enrolled in medicare, parts A and B, a health care corporation shall refund all premiums received from the person for a medicare supplement certificate issued to the person plus interest less the amount of any benefits received by the person under the certificate.

(2) Interest under subsection (1) shall be calculated at 6-month intervals from the date the first premium payment was received at a rate of interest equal to 1% plus the average interest rate paid at auctions of 5-year United States treasury notes during the 6 months immediately preceding July 1 and January 1, as certified by the state treasurer, and compounded annually.

History: Add. 1994, Act 40, Imd. Eff. Mar. 14, 1994.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1473 Medicare supplement certificate; definitions and terms.

Sec. 473. A health care corporation certificate shall not be titled, advertised, solicited, or issued for delivery in this state as a medicare supplement certificate unless the definitions and terms contained in the certificate are such that covered benefits under the certificate are not more restrictive than covered benefits under medicare and those required to be provided under state law. A medicare supplement certificate shall contain a definition of medicare as that term is defined in section 451 or substantially similar to that definition.

History: Add. 1994, Act 40, Imd. Eff. Mar. 14, 1994.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1475 Preexisting diseases or physical conditions; waivers to exclude, limit, or reduce coverage or benefits prohibited.

Sec. 475. A medicare supplement certificate shall not use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

History: Add. 1994, Act 40, Imd. Eff. Mar. 14, 1994.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1477 Duplication of benefits; statements and questions.

Sec. 477. (1) A medicare supplement certificate shall not be delivered or issued for delivery in this state if the certificate provides benefits that duplicate benefits provided by medicare.

(2) Application forms or a supplementary application or other form to be signed by the applicant and agent for medicare supplement certificates shall include the following statements and questions designed to inform and elicit information as to whether, as of the date of the application, the applicant has another medicare supplement or other health insurance policy, contract, or certificate in force or whether a medicare supplement certificate is intended to replace any disability or other health certificate presently in force:

[Statements]

(1) You do not need more than 1 medicare supplement certificate.

(2) If you are 65 or older, you may be eligible for benefits under medicaid and may not need a medicare supplement certificate.

(3) The benefits and premiums under your medicare supplement certificate will be suspended during your entitlement to benefits under medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for medicaid. If you are no longer entitled to medicaid, your certificate will be reinstituted if requested within 90 days of losing medicaid eligibility.

(4) Counseling services may be available in your state to provide advice concerning your purchase of medicare supplement coverage and concerning medicaid.

[Questions]

These questions should be answered to the best of your knowledge.

(1) Do you have another medicare supplement insurance policy, contract, or certificate in force (including an insurance policy or health maintenance organization contract)? If so, with which company?

(2) Do you have any other health insurance policies, certificates, or contracts that provide benefits that this medicare supplement certificate would duplicate? If so, with which company? What kind of policy, contract, or certificate?

(3) If the answer to question 1 or 2 is yes, do you intend to replace these disability or health policies, certificates, or contracts with this certificate?

(4) Are you covered by medicaid?

(3) An agent shall list on the application form for a medicare supplement certificate any other health insurance policies, certificates, or contracts he or she has sold to the applicant, including policies, certificates, or contracts sold that are still in force and policies, certificates, and contracts sold in the past 5 years that are no longer in force.

(4) For a direct response health care corporation, a copy of the application or supplement form, signed by the applicant, and acknowledged by the health care corporation, shall be returned to the applicant by the health care corporation upon delivery of the certificate.

(5) Upon determining that a sale will involve replacement of medicare supplement coverage, a health care corporation, other than a direct response health care corporation or its agent, shall furnish the applicant prior to issuance or delivery of the medicare supplement certificate the following notice regarding replacement of medicare supplement coverage. One copy of the notice signed by the applicant and the agent, except where coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the health care corporation. A direct response health care corporation shall deliver to the applicant at the time of issuance of the certificate the following notice regarding replacement of medicare supplement coverage. The notice regarding replacement of medicare supplement coverage shall be provided in substantially the following form and in not less than 10-point type:

"Notice to applicant regarding replacement of medicare supplement coverage

(Health care corporation's name and address)

SAVE THIS NOTICE! It may be important to you in the future.

According to (your application) (information you have furnished), you intend to drop or otherwise terminate existing medicare supplement coverage and replace it with a certificate to be issued by (health care corporation name). Your new certificate provides 30 days within which you may decide without cost whether you desire to keep the certificate.

You should review this new coverage carefully comparing it with all disability and other health coverage you now have and terminate your present coverage only if, after due consideration, you find that purchase of this medicare supplement coverage is a wise decision.

Statement to applicant by health care corporation, agent, or other representative:

(Use additional sheets as necessary.)

I have reviewed your current medical or health coverage. The replacement of coverage involved in this transaction does not duplicate coverage, to the best of my knowledge. The replacement certificate is being purchased for the following reasons (check 1):

_____ Additional benefits

_____ No change in benefits, but lower premiums

_____ Fewer benefits and lower premiums

_____ Other. (Please specify)

1. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new certificate. This could result in denial or delay of a claim for benefits under the new certificate, whereas a similar claim might have been payable under your present policy, contract, or certificate. (This paragraph may be deleted by a health care corporation if the replacement does not involve application of a new preexisting condition limitation.)

2. Your health care corporation will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new certificate for similar benefits to the extent such time was spent or depleted under the original coverage. (This paragraph may be deleted by a health care corporation if the replacement does not involve application of a new preexisting condition limitation.)

3. If, after thinking about it carefully, you still wish to drop your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the health care corporation to deny any future claims and to refund your premium as though your certificate had never been in force. After the application has been completed, and before you sign it, review it carefully to be certain that all information has been properly recorded. (If the certificate is guaranteed issue, this paragraph need not appear.)

4. Do not cancel your present policy, contract, or certificate until you have received your new certificate and are sure that you want to keep it.

Signature of Agent, Broker, or Other Representative(* Signature not required for direct response sales.)

Typed Name and Address of Agent or Broker

(Date)

The above "Notice to Applicant" was delivered to me on:

(Date)

(Applicant's Signature)

(Applicant's Printed Name)

(Applicant's Address)

(Policy, Certificate, or Contract Number being Replaced)"

History: Add. 1994, Act 40, Imd. Eff. Mar. 14, 1994.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1479 Medicare supplement certificate; denial or conditioning of issuance or discrimination in pricing prohibited; conditions; availability of certificate; excluded benefits based on preexisting condition; prohibition; "creditable coverage" defined.

Sec. 479. (1) A health care corporation shall not deny or condition the issuance or effectiveness of a medicare supplement certificate available for sale in this state, or discriminate in the pricing of such a certificate, because of the health status, claims experience, receipt of health care, or medical condition of an applicant if an application for the certificate is submitted during the 6-month period beginning with the first month in which an individual who is 65 years of age or older first enrolled for benefits under medicare part B. Each medicare supplement certificate currently available from a health care corporation shall be made available to all applicants who qualify under this section without regard to age.

(2) If an applicant qualifies under subsection (1), submits an application during the time period provided in subsection (1), and as of the date of application has had a continuous period of creditable coverage of not less than 6 months, the health care corporation shall not exclude benefits based on a preexisting condition. If the applicant qualifies under subsection (1), submits an application during the time period in subsection (1), and as of the date of

application has had a continuous period of creditable coverage that is less than 6 months, the health care corporation shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The secretary shall specify the manner of the reduction under this subsection.

(3) Except as provided in subsection (2) and section 483, subsection (1) does not prevent the exclusion of benefits under a certificate, during the first 6 months, based on a preexisting condition for which the member received treatment or was otherwise diagnosed during the 6 months before the coverage became effective.

(4) "Creditable coverage" does not include any of the following:

(a) One or more of the following:

(*i*) Coverage only for accident or disability income insurance, or any combination of accident or disability income insurance.

(*ii*) Coverage issued as a supplement to liability insurance.

(*iii*) Liability insurance, including general liability insurance and automobile liability insurance.

(*iv*) Workers' compensation or similar insurance.

(*v*) Automobile medical payment insurance.

(*vi*) Credit-only insurance.

(*vii*) Coverage for on-site medical clinics.

(*viii*) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(b) The following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(*i*) Limited scope dental or vision benefits.

(*ii*) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination of long-term care, nursing home care, home health care, or community-based care.

(*iii*) Such other similar, limited benefits as are specified in federal regulations.

(c) The following benefits if offered as independent, noncoordinated benefits:

(*i*) Coverage only for a specified disease or illness.

(*ii*) Hospital indemnity or other fixed indemnity insurance.

(d) The following if it is offered as a separate policy, certificate, or contract of insurance:

(*i*) Medicare supplemental policy as defined under section 1882(g)(1) of part D of medicare, 42 U.S.C. 1395ss.

(*ii*) Coverage supplemental to the coverage provided under chapter 55 of title 10 of the United States Code, 10 U.S.C. 1071 to 1109.

(*iii*) Similar supplemental coverage provided to coverage under a group health plan.

History: Add. 1994, Act 40, Imd. Eff. Mar. 14, 1994;—Am. 2002, Act 559, Imd. Eff. Sept. 27, 2002.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1480 Eligibility provisions.

Sec. 480. (1) An eligible person is an individual described in subsection (2) who applies to enroll under a medicare supplement certificate during the period described in subsection (3), and who submits evidence of the date of termination or disenrollment with the application for a medicare supplement certificate. For an eligible person, a health care corporation shall not deny or condition the issuance or effectiveness of a medicare supplement certificate described in subsections (5), (6), and (7) that is offered and is available for issuance to new enrollees by the health care corporation, shall not discriminate in the pricing of the medicare supplement certificate because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under the medicare supplement certificate.

(2) An eligible person under this section is an individual that meets any of the following:

(a) Is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under medicare and the plan terminates or the plan ceases to provide all those supplemental health benefits to the individual.

(b) Is enrolled with a medicare+choice organization under a medicare+choice plan under part C of medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a PACE provider under section 1894 of the social security act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with the provider if the individual were enrolled in a medicare+choice plan:

(*i*) The certification of the organization or plan has been terminated.

(*ii*) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides.

(*iii*) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(b) of the social security act, where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards established under section 1856 of the social security act, or the plan is terminated for all individuals within a residence area.

(*iv*) The individual demonstrates, in accordance with guidelines established by the secretary, that the organization offering the plan substantially violated a material provision of the organization's contract in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide covered care in accordance with applicable quality standards, or the organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual.

(*v*) The individual meets other exceptional conditions as the secretary may provide.

(c) Is enrolled with an eligible organization under a contract under section 1876 of the social security act, a similar organization operating under demonstration project authority, effective for periods before April 1, 1999, an organization under an agreement under section 1833(a)(1)(a) of the social security act, a health care prepayment plan, or an organization under a medicare select policy or certificate, and the enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under subdivision (b).

(d) Is enrolled under a medicare supplement policy or certificate and the enrollment ceases because of any of the following:

(*i*) The insolvency of the insurer or health care corporation or bankruptcy of the noninsurer organization or of other involuntary termination of coverage or enrollment under the policy or certificate.

(*ii*) The insurer or health care corporation substantially violated a material provision of the policy or certificate.

(*iii*) The insurer or health care corporation or an agent or other entity acting on the insurer's or health care corporation's behalf, materially misrepresented the policy's or certificate's provisions in marketing the policy or certificate to the individual.

(e) Was enrolled under a medicare supplement policy or certificate and terminates enrollment and subsequently enrolls, for the first time, with any medicare+choice organization under a medicare+choice plan under part C of medicare, any eligible organization under a contract under section 1876 of the social security act, medicare cost, any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the social security act, or a medicare select policy or certificate; and the subsequent enrollment is terminated by the individual during any period within the first 12 months of the subsequent enrollment during which the individual is permitted to terminate the subsequent enrollment under section 1851(e) of the social security act.

(f) Upon first becoming eligible for benefits under part A of medicare at age 65, enrolls in a medicare+choice plan under part C of medicare, or with a PACE provider under section 1894 of the social security act, and disenrolls from the plan or program by not later than 12 months after the effective date of enrollment.

(3) The guaranteed issue time periods under this section are as follows:

(a) For an individual described in subsection (2)(a), the guaranteed issue time period begins on the date the individual receives a notice of termination or cessation of all supplemental health benefits or, if a notice is not received, notice that a claim has been denied because of a termination or cessation, and ends 63 days after the date of the applicable notice.

(b) For an individual described in subsection (2)(b), (c), (e), or (f) whose enrollment is terminated involuntarily, the guaranteed issue time period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated.

(c) For an individual described in subsection (2)(d)(*i*), the guaranteed issue time period begins on the earlier of the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice, if any, or the date that the applicable coverage is terminated, and ends on the date that is 63 days after the date the coverage is terminated.

(d) For an individual described in subsection (2)(b), (d)(*ii*), (d)(*iii*), (e), or (f) who disenrolls voluntarily, the guaranteed issue time period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date.

(e) For an individual described in subsection (2) but not described in subdivisions (a) to (d), the guaranteed issue

time period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date.

(4) For an individual described in subsection (2)(e) whose enrollment with an organization or provider described in subsection (2)(e) is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be considered an initial enrollment described in subsection (2)(e). For an individual described in subsection (2)(f) whose enrollment within a plan or in a program described in subsection (2)(f) is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be considered an initial enrollment described in subsection (2)(f). For purposes of subsections (2)(e) and (f), an enrollment of an individual with an organization or provider described in subsection (2)(e), or with a plan or provider described in subsection (2)(f), shall not be considered to be an initial enrollment after the 2-year period beginning on the date on which the individual first enrolled with such an organization, provider, or plan.

(5) The medicare supplement certificate to which an eligible person is entitled under subsection (2)(a), (b), (c), and (d) is a medicare supplement certificate that has a benefit package classified as plan a, b, c, or f offered by any health care corporation.

(6) The medicare supplement certificate to which an eligible person is entitled under subsection (2)(e) is the same medicare supplement certificate in which the individual was most recently previously enrolled, if available from the same health care corporation, or, if not so available, a certificate described in subsection (5).

(7) The medicare supplement certificate to which an eligible person is entitled under subsection (2)(f) shall include any medicare supplement certificate offered by any health care corporation.

History: Add. 2002, Act 559, Imd. Eff. Sept. 27, 2002.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1480a Cessation of enrollment; notification.

Sec. 480a. (1) At the time of an event described in section 480(2) because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, certificate, or plan, the organization that terminates the contract or agreement, the insurer terminating the policy, the health care corporation terminating the certificate, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under section 480 and of the obligations of health care corporations of medicare supplement certificates under section 480(1). The notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in section 480(2) because of which an individual ceases enrollment under a contract or agreement, policy, certificate, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the insurer offering the policy, the health care corporation offering the certificate, or the administrator of the plan, respectively, shall notify the individual of his or her rights under section 480 and of the obligations of health care corporations providing medicare supplement certificates under section 480(1). The notice shall be communicated within 10 working days of the health care corporation receiving notification of disenrollment.

History: Add. 2002, Act 559, Imd. Eff. Sept. 27, 2002.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1481 Person eligible for medicare; right of continuation or conversion to supplemental coverage; conditions; availability of coverage.

Sec. 481. (1) Each health care corporation offering nongroup or group certificates in this state shall provide without restriction, to any person who requests coverage from a health care corporation and has been covered by an insurer, health maintenance organization, or health care corporation if the person would no longer be covered because he or she has become eligible for medicare or if the person loses coverage under a group certificate after becoming eligible for medicare, a right of continuation or conversion to their choice of the basic core benefits as described in section 455 or a type C medicare supplemental package as described in section 461(5)(c) that is guaranteed renewable or noncancellable. A person who is hospitalized or has been informed by a physician that he or she will require hospitalization within 30 days after the time of application shall not be entitled to coverage under this subsection until the day following the date of discharge. However, if the hospitalized person was covered by the health care corporation immediately prior to becoming eligible for medicare or immediately prior to losing coverage under a group certificate after becoming eligible for medicare, the person shall be eligible for immediate

coverage from the previous insurer, health maintenance organization, or health care corporation under this subsection. A person shall not be entitled to a medicare supplemental certificate under this subsection unless the person presents satisfactory proof to the health care corporation that he or she was covered by an insurer, health maintenance organization, or health care corporation. A person who wishes coverage under this subsection must either request coverage within 90 days before or 90 days after the month he or she becomes eligible for medicare or request coverage within 180 days after losing coverage under a group policy, contract, or certificate. A person 60 years of age or older who loses coverage under a group policy or certificate is entitled to coverage under a medicare supplemental certificate without restriction from the health care corporation providing the former group coverage, if he or she requests coverage within 90 days before or 90 days after the month he or she becomes eligible for medicare.

(2) Except as provided in section 483, a person not covered under a nongroup or group certificate as specified in subsection (1), after applying for coverage under a medicare supplemental certificate required to be offered under subsection (1), is entitled to coverage under a medicare supplemental certificate that may include a provision for exclusion from preexisting conditions for 6 months after the inception of coverage, consistent with the provisions of section 469(2)(a).

(3) Each health care corporation offering nongroup certificates in this state shall give to each person who is covered with the health care corporation at the time he or she becomes eligible for medicare, and to each applicant of the health care corporation who is eligible for medicare, written notice of the availability of coverage under this section. Each group certificate holder in this state shall give to each member who is covered at the time he or she becomes eligible for medicare, written notice of the availability of coverage under this section.

History: Add. 1994, Act 40, Imd. Eff. Mar. 14, 1994.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1483 Replacement of certificate; waiver of time periods by health care corporation.

Sec. 483. If a medicare supplement certificate replaces another medicare supplement policy, contract, or certificate, the replacing health care corporation shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new medicare supplement certificate for similar benefits to the extent such time was spent under the original coverage.

History: Add. 1994, Act 40, Imd. Eff. Mar. 14, 1994.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1485 Medicare supplement coverage; marketing; duties of health care corporation and agents; providing individual with more than 1 policy, contract, or certificate prohibited; display of notice.

Sec. 485. (1) Each health care corporation marketing medicare supplement coverage in this state directly or through its agents shall do all of the following:

(a) Establish marketing procedures to ensure that any comparison of policies by its agents will be fair and accurate.

(b) Establish marketing procedures to ensure excessive coverage is not sold or issued.

(c) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant for medicare supplement coverage already has disability or other health coverage and the types and amounts of coverage.

(d) Establish auditable procedures for verifying compliance with this subsection.

(2) In recommending the purchase or replacement of any medicare supplement coverage, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(3) Any sale of medicare supplement coverage that will provide an individual with more than 1 medicare supplement policy, contract, or certificate is prohibited.

(4) A medical supplement certificate shall display prominently by type, stamp, or other appropriate means, on the first page of the certificate the following: “Notice to buyer: This certificate may not cover all of your medical expenses.”

History: Add. 1994, Act 40, Imd. Eff. Mar. 14, 1994.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1487 Repealed. 2002, Act 559, Imd. Eff. Sept. 27, 2002.

Compiler's note: The repealed section pertained to report to commissioner.
Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1491 Renewal, continuation, or conversion of coverage; replacement of coverage.

Sec. 491. (1) Each medicare supplement certificate shall include a renewal or continuation provision. The provision shall be appropriately captioned, shall appear on the first page of the certificate, and shall clearly state the term of coverage for which the certificate is issued and for which it may be renewed. The provision shall include any reservation by the health care corporation of the right to change premiums and any automatic renewal premium increases based on the certificate holder's age.

(2) If a medicare supplement certificate is terminated by the group certificate holder and is not replaced as provided under subsection (4), the health care corporation shall offer certificate holders a nongroup medicare supplement certificate that at the option of the certificate holder provides for continuation of the benefits contained in the group certificate or provides for such benefits as otherwise meet the requirements of section 469.

(3) If an individual is a certificate holder in a group medicare supplement certificate and the individual terminates membership in the group, the health care corporation shall offer the certificate holder the conversion opportunity described in subsection (2) or at the option of the group certificate holder, offer the certificate holder continuation of coverage under the group certificate.

(4) If a group medicare supplement policy, contract, or certificate is replaced by another group medicare supplement policy, contract, or certificate purchased by the same certificate holder, the succeeding issuer shall offer coverage to all persons covered under the old group policy, contract, or certificate on its date of termination. Coverage under the new certificate shall not result in any exclusion for preexisting conditions that would have been covered under the group policy, contract, or certificate being replaced.

History: Add. 1994, Act 40, Imd. Eff. Mar. 14, 1994.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1493 Rider, endorsement, or certificate form.

Sec. 493. (1) Except for riders or endorsements by which the health care corporation effectuates a request made in writing by the subscriber, exercises a specifically reserved right under a medicare supplement certificate, or as required to reduce or eliminate benefits to avoid duplication of medicare benefits, all riders or endorsements added to a medicare supplement certificate after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the certificate shall require signed acceptance by the subscriber. After the date of certificate issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the certificate term shall be agreed to in writing and signed by the subscriber, unless the benefits are required minimum standards for medicare supplement certificates or if the increase in benefits or coverage is required by law. If a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charged shall be set forth in the certificate.

(2) A medicare supplement certificate shall not provide for the payment of benefits based on standards described as “usual and customary”, “reasonable and customary”, or words of similar import.

(3) If a medicare supplement certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the certificate and shall be labeled as “preexisting condition limitations”.

(4) The term “medicare supplement”, “medigap”, “medicare wrap-around”, or words of similar import shall not be used unless the certificate is issued in compliance with this part.

(5) A medicare supplement certificate shall have a notice prominently printed on the first page or attached thereto stating that a member shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the certificate, the member is not satisfied for any reason.

(6) As soon as practicable but prior to the effective date of any changes in medicare benefits, every health care corporation offering medicare supplement coverage in this state shall file with the commissioner any appropriate riders, endorsements, or certificate forms needed to accomplish the medicare supplement modifications necessary to eliminate benefits under the certificate that duplicate benefits provided by medicare. The riders, endorsements, and certificate forms shall provide a clear description of the medicare supplement benefits provided by the certificate.

(7) Upon satisfying the filing and approval requirements, a health care corporation providing medicare supplement certificates delivered or issued for delivery in this state shall provide to each covered certificate holder

any rider, endorsement, or certificate form necessary to eliminate benefits under the certificate that duplicate benefits provided by medicare.

(8) As soon as practicable but no later than 30 days before the annual effective date of any medicare benefit changes, every health care corporation delivering or issuing for delivery in this state medicare supplement certificates shall notify each covered certificate holder of modifications made to its medicare supplement certificates in a format acceptable to the commissioner. The notice shall be in outline form, contain clear and simple language, shall not contain or be accompanied by any solicitation, and shall include both of the following:

(a) A description of revisions to the medicare program and of each modification made to the coverage provided under the medicare supplement certificate.

(b) Whether a premium adjustment is due to changes in medicare.

History: Add. 1994, Act 40, Imd. Eff. Mar. 14, 1994.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1495 Persons eligible for medicare; notice; applicability of subsection (1).

Sec. 495. (1) Any certificate issued for delivery in this state to persons eligible for medicare by reason of age shall notify subscribers under the certificate that the certificate is not a medicare supplement certificate. The notice shall either be printed or attached to the first page of the coverage outline delivered to subscribers under the certificate, or if a coverage outline is not delivered, to the first page of the certificate delivered to subscribers. The notice shall be in not less than 12-point type, and shall contain the following language:

"This certificate is not a medicare supplement certificate. It is not designed to fit with medicare. It may not fit all of the gaps in medicare and it may duplicate some medicare benefits. If you are eligible for medicare, review the medicare supplement buyer's guide available from the company. If you decide to consider buying this certificate, be sure you understand what it covers, what it does not cover, and whether it duplicates coverage you already have."

(2) Subsection (1) does not apply to a medicare supplement certificate.

History: Add. 1994, Act 40, Imd. Eff. Mar. 14, 1994.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1496 Marketing or sale of medicare supplement coverage; prohibited acts and practices.

Sec. 496. The following acts and practices are prohibited in the marketing or sale of medicare supplement coverage:

(a) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies, certificates, or contracts of insurers, health care corporations, or health maintenance organizations for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy, contract, or certificate or to take out a policy, certificate, or contract with another insurer, health care corporation, or health maintenance organization.

(b) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of health coverage through force, fright, threat whether explicit or implied, or undue pressure to purchase or recommend the purchase of health coverage.

(c) Cold lead advertising. Making use directly or indirectly of any method of marketing that fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of health coverage and that contact will be made by a health care corporation agent or company.

History: Add. 1994, Act 40, Imd. Eff. Mar. 14, 1994.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1497 Medicare supplement coverage; filing copy of advertisement with commissioner.

Sec. 497. Each health care corporation providing medicare supplement coverage in this state shall file with the commissioner for review a copy of any written, radio, or television advertisement for medicare supplement coverage intended for use in this state at least 45 days before the date the health care corporation desires to use the advertising. The filing shall include a sample or photocopy of all applicable medicare supplement certificates and related forms and the approval status of the certificates and forms.

History: Add. 1994, Act 40, Imd. Eff. Mar. 14, 1994.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1498 Medicare supplement certificate form; filing and approval; use or change of premium rates; filing more than 1 form of certificate prohibited; exception; availability for purchase; discontinuance; compliance with social security act; "type" defined.

Sec. 498. (1) A health care corporation shall not deliver or issue for delivery a medicare supplement certificate to a resident of this state unless the certificate form has been filed with and approved by the commissioner in accordance with filing requirements and procedures prescribed by the commissioner.

(2) A health care corporation shall not use or change premium rates for a medicare supplement certificate unless the rates, rating schedule, and supporting documentation have been filed with and approved by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner.

(3) Except as provided in subsection (4), a health care corporation shall not file for approval more than 1 form of a certificate for each group and nongroup standard medicare supplement benefit plan.

(4) With the approval of the commissioner, a health care corporation may offer up to 4 additional certificate forms of the same type for the same standard medicare supplement benefit plan, 1 for each of the following cases:

(a) The inclusion of new or innovative benefits.

(b) The addition of either direct response or agent marketing methods.

(c) The addition of either guaranteed issue or underwritten coverage.

(d) The offering of coverage to individuals eligible for medicare by reason of disability.

(5) Except as provided in subsection (6), a health care corporation shall continue to make available for purchase any medicare supplement certificate form issued after the effective date of this part that has been approved by the commissioner. A medicare supplement certificate form shall not be considered to be available for purchase unless the health care corporation has actively offered it for sale in the previous 12 months.

(6) A health care corporation may discontinue the availability of a medicare supplement certificate form if the health care corporation provides to the commissioner in writing its decision to discontinue at least 30 days prior to discontinuing the availability of the form of the medicare supplement certificate. After receipt of the notice by the commissioner, the health care corporation shall no longer offer for sale the medicare supplement certificate form in this state.

(7) A health care corporation that discontinues the availability of a medicare supplement certificate form pursuant to subsection (6) shall not file for approval a new medicare supplement certificate form of the same type for the same standard medicare supplement benefit plan as the discontinued form for a period of 5 years after the health care corporation provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

(8) The sale or other transfer of medicare supplement business to another insurer, health maintenance organization, or health care corporation shall be considered a discontinuance for the purposes of this section.

(9) Each health care corporation that issues medicare supplement certificates for delivery in this state shall comply with sections 1842 and 1882 of title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395u and 1395ss, and shall certify that compliance on the medicare supplement experience reporting form.

(10) For the purposes of this section, "type" means a group certificate, a nongroup certificate, a group medicare select certificate, or a nongroup medicare select certificate.

History: Add. 1994, Act 40, Imd. Eff. Mar. 14, 1994.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1499 Health care corporation; duties.

Sec. 499. (1) A health care corporation shall do all of the following:

(a) Accept a notice from a medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and make a payment determination on the basis of the information contained in that notice.

(b) Notify the participating physician or supplier and the beneficiary of the payment determination.

(c) Pay the participating physician or supplier directly.

(d) At the time of enrollment, furnish each enrollee with a card listing the certificate name, number, and a central mailing address to which notices from a medicare carrier may be sent.

(e) Pay user fees for claim notices that are transmitted electronically or otherwise.

(f) Provide to the secretary of health and human services, at least annually, a central mailing address to which all claims may be sent by medicare carriers.

(2) Compliance with the requirements set forth in subsection (1) shall be certified on the medicare supplement

insurance experience reporting form.

History: Add. 1994, Act 40, Imd. Eff. Mar. 14, 1994.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1499a Prohibited conduct; violation as misdemeanor; penalty.

Sec. 499a. (1) A person shall not knowingly sell a health care corporation certificate to an individual entitled to benefits under part A or enrolled under part B of medicare with knowledge that the certificate substantially duplicates health benefits to which the individual is otherwise entitled, other than benefits to which the individual is entitled under a requirement of state or federal law other than medicare. A person who violates this subsection is guilty of a misdemeanor punishable by imprisonment for not more than 2 years, or a fine of not more than $10,000.00, or both. The court may order a person convicted under this subsection to pay restitution to individuals for expenses incurred as a result of violation of this subsection. For purposes of this subsection, benefits that are payable to or on behalf of an individual without regard to other health benefit coverage of the individual shall not be considered as duplicative. The selling of a group certificate of the trustees of a fund established by 1 or more employers, labor organizations, or both, for employees, former employees, or both, or for members or former members, or both, of labor organizations, shall not be considered to be a violation of this subsection.

(2) A person shall not falsely assume or pretend to be acting or misrepresent in any way that he or she is acting under the authority of or in association with medicare or any state or federal agency, for the purpose of selling or attempting to sell health coverage or, in such a pretended character, demand or obtain money, paper, documents, or any thing of value. A person who violates this subsection is guilty of a misdemeanor punishable by imprisonment for not more than 2 years, or a fine of not more than $10,000.00, or both.

(3) A person shall not solicit, offer for sale, or deliver a medicare supplement certificate in this state, unless the certificate has been approved by the commissioner. A person who violates this subsection is guilty of a misdemeanor punishable by imprisonment for not more than 1 year, or a fine of not more than $5,000.00, or both.

History: Add. 1994, Act 40, Imd. Eff. Mar. 14, 1994.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

PART 5

550.1501 Contracts with health care facilities.

Sec. 501. (1) A health care corporation subject to this act may enter into contracts with health care facilities in Michigan or health facilities in any other jurisdiction. It is the intent of the legislature that contracts with health facilities outside of Michigan expand access to health care without reducing access to Michigan licensed health facilities.

(2) Contracts entered into under this section with health care facilities licensed in Michigan are subject to the provisions of sections 504 to 518.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 2003, Act 60, Imd. Eff. July 15, 2003.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1501a Special participating contracts with health care providers for provision of primary health care benefits to children enrolled in Michigan caring program.

Sec. 501a. A health care corporation may enter into special participating contracts with health care providers for the provision of primary health care benefits to children enrolled in a Michigan caring program created under section 436. Special participating contracts entered into under this section are not subject to sections 502 to 518.

History: Add. 1991, Act 73, Imd. Eff. July 11, 1991.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1501b Conduct on behalf of or information provided to subscriber by health care provider; prohibition or discouragement by health care corporation.

Sec. 501b. A health care corporation shall not prohibit or discourage a health care provider from advocating on

behalf of a subscriber for appropriate medical treatment options pursuant to the grievance procedure in section 404 or from discussing with a subscriber or provider any of the following:

(a) Health care treatments and services.

(b) Quality assurance plans required by law, if applicable.

(c) The financial relationships between the health care corporation and the health care provider including all of the following as applicable:

(*i*) Whether a fee-for-service arrangement exists, under which the provider is paid a specified amount for each covered service rendered to the participant.

(*ii*) Whether a capitation arrangement exists, under which a fixed amount is paid to the provider for all covered services that are or may be rendered to each covered individual or family.

(*iii*) Whether payments to providers are made based on standards relating to cost, quality, or patient satisfaction.

History: Add. 1997, Act 68, Imd. Eff. July 15, 1997.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1502 Contracts for reimbursement with professional health care providers; private provider-patient relationship; methods of diagnosis or treatment not to be restricted; refusal to reimburse for overutilized services; choice of providers; list of providers; recommendation of provider as misdemeanor; symbol of participation; health maintenance organization not impeded; contracts subject to §§ 550.1504 to 550.1518; participation of freestanding surgical outpatient facility; optometric services; status of license or registration.

Sec. 502. (1) A health care corporation may enter into participating contracts for reimbursement with professional health care providers practicing legally in this state for health care services or with health practitioners practicing legally in any other jurisdiction for health care services that the professional health care providers or practitioners may legally perform. A participating contract may cover all members or may be a separate and individual contract on a per claim basis, as set forth in the provider class plan, if, in entering into a separate and individual contract on a per claim basis, the participating provider certifies to the health care corporation:

(a) That the provider will accept payment from the corporation as payment in full for services rendered for the specified claim for the member indicated.

(b) That the provider will accept payment from the corporation as payment in full for all cases involving the procedure specified, for the duration of the calendar year. As used in this subdivision, provider does not include a person licensed as a dentist under part 166 of the public health code, 1978 PA 368, MCL 333.16601 to 333.16648.

(c) That the provider will not determine whether to participate on a claim on the basis of the race, color, creed, marital status, sex, national origin, residence, age, disability, or lawful occupation of the member entitled to health care benefits.

(2) A contract entered into pursuant to subsection (1) shall provide that the private provider-patient relationship shall be maintained to the extent provided for by law. A health care corporation shall continue to offer a reimbursement arrangement to any class of providers with which it has contracted prior to August 27, 1985 and that continues to meet the standards set by the corporation for that class of providers.

(3) A health care corporation shall not restrict the methods of diagnosis or treatment of professional health care providers who treat members. Except as otherwise provided in section 502a, each member of the health care corporation shall at all times have a choice of professional health care providers. This subsection does not apply to limitations in benefits contained in certificates, to the reimbursement provisions of a provider contract or reimbursement arrangement, or to standards set by the corporation for all contracting providers. A health care corporation may refuse to reimburse a health care provider for health care services that are overutilized, including those services rendered, ordered, or prescribed to an extent that is greater than reasonably necessary.

(4) A health care corporation may provide to a member, upon request, a list of providers with whom the corporation contracts, for the purpose of assisting a member in obtaining a type of health care service. However, except as otherwise provided in section 502a, an employee, agent, or officer of the corporation, or an individual on the board of directors of the corporation, shall not make recommendations on behalf of the corporation with respect to the choice of a specific health care provider. Except as otherwise provided in section 502a, an employee, agent, or officer of the corporation, or a person on the board of directors of the corporation who influences or attempts to influence a person in the choice or selection of a specific professional health care provider on behalf of the corporation, is guilty of a misdemeanor.

(5) A health care corporation shall provide a symbol of participation, which can be publicly displayed, to

providers who participate on all claims for covered health care services rendered to subscribers.

(6) This section does not impede the lawful operation of, or lawful promotion of, a health maintenance organization owned by a health care corporation.

(7) Contracts entered into under this section with professional health care providers licensed in this state are subject to the provisions of sections 504 to 518.

(8) A health care corporation shall not deny participation to a freestanding surgical outpatient facility on the basis of ownership if the facility meets the reasonable standards set by the health care corporation for similar facilities, is licensed under part 208 of the public health code, 1978 PA 368, MCL 333.20801 to 333.20821, and complies with part 222 of the public health code, 1978 PA 368, MCL 333.22201 to 333.22260.

(9) Notwithstanding any other provision of this act, if a certificate provides for benefits for services that are within the scope of practice of optometry, a health care corporation is not required to provide benefits or reimburse for a practice of optometric service unless that service was included in the definition of practice of optometry under section 17401 of the public health code, 1978 PA 368, MCL 333.17401, as of May 20, 1992.

(10) Notwithstanding any other provision of this act, a health care corporation is not required to reimburse for services otherwise covered under a certificate if the services were performed by a member of a health care profession, which health care profession was not licensed or registered by this state on or before January 1, 1998 but that becomes a health care profession licensed or registered by this state after January 1, 1998. This subsection does not change the status of a health care profession that was licensed or registered by this state on or before January 1, 1998.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1984, Act 230, Eff. Dec. 20, 1984;—Am. 1988, Act 38, Eff. Mar. 30, 1989;—Am. 1993, Act 127, Imd. Eff. July 21, 1993;—Am. 1994, Act 440, Eff. Mar. 30, 1995;—Am. 1997, Act 184, Imd. Eff. Dec. 30, 1997;—Am. 1998, Act 24, Imd. Eff. Mar. 12, 1998;—Am. 1998, Act 446, Imd. Eff. Dec. 30, 1998;—Am. 2003, Act 59, Eff. July 23, 2003.

Compiler's note: Neither Senate Bill No. 493 nor House Bill No. 4494 was enacted into law by the 87th Legislature.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1502a Prudent purchaser agreements; group contracts; options; group contracts under which financial or other advantage realized; additional option; applicability of subsection (5); individual contracts; rates; contracts subject to §§ 550.1504 to 550.1518; discrimination against class of health care providers; provisions inapplicable to certain contracts or renewals; optometric and chiropractic services; status of license or registration.

Sec. 502a. (1) For the purpose of doing business as an organization under the prudent purchaser act, 1984 PA 233, MCL 550.51 to 550.63, a health care corporation may enter into prudent purchaser agreements with health care providers pursuant to this section and the prudent purchaser act, 1984 PA 233, MCL 550.51 to 550.63.

(2) A health care corporation may offer group contracts under which subscribers shall be required, as a condition of coverage, to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.

(3) An individual who is a member of a group who is offered the option of being a subscriber under a contract pursuant to subsection (2) shall also be offered the option of being a subscriber under a contract pursuant to subsection (4). This subsection applies only if the group in which the individual is a member has 25 or more members or if the provider panel that is providing the services under the contract is limited by the organization to a specific number pursuant to section 3(1) of the prudent purchaser act, 1984 PA 233, MCL 550.53.

(4) A health care corporation may offer group contracts under which subscribers who elect to obtain services from health care providers who have entered into prudent purchaser agreements shall realize a financial advantage or other advantage by selecting such providers. Contracts offered pursuant to this subsection shall not, as a condition of coverage, require subscribers to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.

(5) An individual who is a member of a group who is offered the option of being a subscriber under a contract pursuant to subsection (2) or (4) shall also be offered the option of being a subscriber under a contract that:

(a) Does not, as a condition of coverage, require subscribers to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.

(b) Does not give a financial advantage or other advantage to a subscriber who elects to obtain services from health care providers who have entered into prudent purchaser agreements.

(6) Subsection (5) applies only if the group in which the individual is a member has 25 or more members and if the group on December 20, 1984 had health care coverage through the group sponsor.

(7) A health care corporation may offer individual contracts under which subscribers shall be required, as a condition of coverage, to obtain services exclusively from health care providers who have entered into prudent purchaser agreements. A person to whom such a contract is offered shall also be offered a contract that:

(a) Does not, as a condition of coverage, require subscribers to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.

(b) Does not give a financial advantage or other advantage to a subscriber who elects to obtain services from health care providers who have entered into prudent purchaser agreements.

(8) A health care corporation may offer individual contracts under which subscribers who elect to obtain services from health care providers who have entered into prudent purchaser agreements shall realize a financial advantage or other advantage by selecting such providers. Contracts offered pursuant to this subsection shall not, as a condition of coverage, require subscribers to obtain services exclusively from health care providers who have entered into prudent purchaser agreements. A person to whom such a contract is offered shall also be offered a contract that:

(a) Does not, as a condition of coverage, require subscribers to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.

(b) Does not give a financial advantage or other advantage to a subscriber who elects to obtain services from health care providers who have entered into prudent purchaser agreements.

(9) The rates charged by a corporation for coverage under contracts issued under this section shall not be unreasonably lower than what is necessary to meet the expenses of the corporation for providing this coverage and shall not have an anticompetitive effect or result in predatory pricing in relation to prudent purchaser agreement coverages offered by other organizations.

(10) Contracts entered into under this section are not subject to the provisions of sections 504 to 518.

(11) A corporation shall not discriminate against a class of health care providers when entering into prudent purchaser agreements with health care providers for its provider panel. This subsection does not:

(a) Prohibit the formation of a provider panel consisting of a single class of providers when a service provided for in the specifications of a purchaser may be legally provided only by a single class of providers.

(b) Prohibit the formation of a provider panel that conforms to the specifications of a purchaser of the coverage authorized by this section so long as the specifications do not exclude any class of health care providers who may legally perform the services included in the coverage.

(c) Require an organization that has uniformly applied the standards filed pursuant to section 3(3) of the prudent purchaser act, 1984 PA 233, MCL 550.53, to contract with any individual provider.

(12) Nothing in the 1984 amendatory act that added this section applies to any contract that was in existence before December 20, 1984, or the renewal of such contract.

(13) Notwithstanding any other provision of this act, if coverage under a prudent purchaser agreement provides for benefits for services that are within the scope of practice of optometry, a health care corporation is not required to provide benefits or reimburse for a practice of optometric service unless that service was included in the definition of practice of optometry under section 17401 of the public health code, 1978 PA 368, MCL 333.17401, as of May 20, 1992.

(14) Notwithstanding any other provision of this act, a health care corporation offering coverage under a prudent purchaser agreement is not required to reimburse for services otherwise covered if the services were performed by a member of a health care profession, which health care profession was not licensed or registered by this state on or before January 1, 1998 but that becomes a health care profession licensed or registered by this state after January 1, 1998. This subsection does not change the status of a health care profession that was licensed or registered by this state on or before January 1, 1998.

History: Add. 1984, Act 230, Eff. Dec. 20, 1984;—Am. 1988, Act 283, Imd. Eff. July 27, 1988;—Am. 1994, Act 440, Eff. Mar 30, 1995;—Am. 1998, Act 446, Imd. Eff. Dec. 30, 1998.

Compiler's note: Neither Senate Bill No. 493 nor House Bill No. 4494 was enacted into law by the 87th Legislature.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1503 Uniform reporting by health care providers.

Sec. 503. In the course of developing and establishing provider class plans under this part, a health care corporation shall address the issue of uniform reporting by health care providers.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1504 Reimbursement arrangements; goals; definitions; supplemental efforts.

Sec. 504. (1) A health care corporation shall, with respect to providers, contract with or enter into a reimbursement arrangement to assure subscribers reasonable access to, and reasonable cost and quality of, health care services, in accordance with the following goals:

(a) There will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber.

(b) Providers will meet and abide by reasonable standards of health care quality.

(c) Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth.

(2) As used in this section:

(a) "Gross national product in constant dollars" means that term as defined and annually published by the United States department of commerce, bureau of economic analysis.

(b) "Implicit price deflator for gross national product" means that term as defined and annually published by the United States department of commerce, bureau of economic analysis.

(c) "Inflation" or "I" means the arithmetic average of the percentage changes in the implicit price deflator for gross national product over the 2 calendar years immediately preceding the year in which the commissioner's determination is being made.

(d) "Compound rate of inflation and real economic growth" means the ratio of the quantity "100 plus inflation", multiplied by the quantity "100 plus real economic growth", to 100; minus 100; or as expressed in the following formula:

$$\left(\frac{(100 + I) \times (100 + REG)}{100} \right) - 100$$

(e) "Rate of change in the total corporation payment per member to each provider class" means the arithmetic average of the percentage changes in the corporation payment per member for that provider class over the 2 years immediately preceding the commissioner's determination.

(f) "Real economic growth" or "REG" means the arithmetic average of the percentage changes in the per capita gross national product in constant dollars over the 4 calendar years immediately preceding the year in which the commissioner's determination is being made.

(3) Nothing in this section shall preclude efforts by a health care corporation supplemental to the goals prescribed in subsection (1).

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1505 Provider class plan; development, modification, implementation, or review; procedures to obtain advice and consultation.

Sec. 505. (1) A health care corporation shall establish and implement procedures to obtain advice and consultation from a provider class, either through individual providers of that class or through 1 or more organizations or associations that represent the provider class, in any combination, in the development of the provider class plan. A health care corporation may negotiate with 1 or more organizations or associations that represent providers in the relevant provider class in the development and modification of the provider class plan and objectives and methods for implementing that plan.

(2) The commissioner shall establish and implement procedures whereby any person, including a subscriber, may offer advice and consultation on the development, modification, implementation, or review of a provider class plan.

(3) A health care corporation shall establish and implement procedures to obtain advice and consultation from subscribers in the development and modification of the provider class plan and objectives for implementing that

plan.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1506 Provider class plan; transmitting to commissioner; examination; determination; notice; placing plan into effect; retention of plan for commissioner's records.

Sec. 506. (1) A health care corporation shall transmit a copy of each provider class plan to the commissioner 45 days before the earliest effective date of a provider contract or reimbursement arrangement for the appropriate provider class. The initial provider class plan for each class, which shall include provider contracts and reimbursement arrangements under which the corporation and a provider class are operating on the effective date of this act, shall be transmitted to the commissioner within 45 days after the effective date of this act, except where a provider class plan reimburses on a prospective basis, in which case the plan shall be transmitted within 1 year and 45 days after the effective date of this act.

(2) Upon receipt of a provider class plan, the commissioner shall examine the plan and shall determine only if the plan contains a reimbursement arrangement and objectives for each goal provided in section 504, and, for those providers with which a health care corporation contracts, provisions that are included in that contract. For purposes of making the determination required by this subsection only, the commissioner shall liberally construe the items contained in a provider class plan.

(3) If the commissioner determines that the plan does not contain a reimbursement arrangement, objectives for each goal provided in section 504, and, for those providers with which a health care corporation contracts, contract provisions, the commissioner, within 15 days after receipt of the plan, shall notify the corporation by certified or registered mail, along with a written statement of the items omitted.

(4) If the commissioner does not notify the health care corporation pursuant to subsection (3), the provider class plan shall be automatically placed into effect, and shall be retained for the commissioner's records. Provider class plans approved by the commissioner or an independent hearing officer under this part shall be considered retained for the commissioner's records under this subsection.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1507 Provider class plan; inclusion and transmittal of items omitted.

Sec. 507. Within 15 days after receipt of the notification as provided in section 506(3), the health care corporation shall include the items omitted from the provider class plan, after taking into consideration any advice and consultation received from providers and subscribers pursuant to section 505, and shall transmit the items omitted, as provided in section 506(1).

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1508 Provider class plan; modifications.

Sec. 508. (1) Except during the 6-month period provided in section 509(2), a provider class plan retained by the commissioner as provided in section 506(4) may be modified by the health care corporation after the retention, under either of the following circumstances:

(a) If the plan was prepared by the health care corporation and is not a plan prepared pursuant to section 511(1) or 515(4). However, the modification shall not take effect until after the modification has been filed with the commissioner.

(b) In all other cases, if the modification has been filed with and is agreed to by the commissioner.

(2) A modification made under subsection (1) shall not extend the time periods provided in section 509(1). In developing plan modifications, a health care corporation shall obtain advice and consultation from providers in the relevant provider class and from subscribers pursuant to section 505. Before agreeing to plan modifications under subsection (1)(b), the commissioner shall obtain advice and consultation pursuant to section 505(2).

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1509 Achievement of goals and objectives; determinations by commissioner.

Sec. 509. (1) The commissioner may determine if the health care corporation has substantially achieved the goals of a corporation as provided in section 504 and achieved the objectives contained in the provider class plan, at the following times:

(a) For a provider contract or a reimbursement arrangement that was in effect prior to the effective date of this act, upon the expiration of 2 years after the filing date under section 506.

(b) For a provider class plan retained by the commissioner as provided in section 506(4), upon the expiration of 2 years after the earliest effective date of the provider contract or a reimbursement arrangement for the appropriate provider class.

(c) For a class plan retained by the commissioner as provided in section 506(4) that has not been subject to a determination under this section within the time period provided in subsection (2), within 2 years after the expiration of that time period.

(2) Before making a determination under subsection (1), and not later than 30 days following expiration of the appropriate 2-year time period described in subsection (1)(a), (b), or (c), the commissioner shall give written notice to the health care corporation, and to each person who has requested a copy of such notice, that he or she intends to make a determination with respect to a particular provider class plan. The commissioner shall have 6 months to reach a determination under subsection (1).

(3) A modification made pursuant to section 508(1) shall not be taken into consideration for purposes of computing the time periods described in subsections (1) and (2).

(4) The commissioner shall consider all of the following in making a determination pursuant to subsection (1):

(a) Annual reports transmitted pursuant to section 517.

(b) The overall balance of the goals provided in section 504, achieved by the health care corporation under the plan. The commissioner shall give weight to each of the goals provided in section 504, shall not focus on 1 goal independently of the other goals of the corporation, and shall assure that no portion of the corporation's fair share of reasonable costs to the provider are borne by other health care purchasers.

(c) Information submitted or obtained for the record concerning: demographic trends; epidemiological trends; and long-term economic trends, including changes in prices of goods and services purchased by a provider class not already reflected in the calculation in section 504(2)(d); sudden changes in circumstances; administrative agency or judicial actions; changes in health care practices and technology; and changes in benefits that affect the ability of the health care corporation to reasonably achieve the goals provided in section 504.

(d) Health care legislation of this state or of the federal government. As used in this subdivision, “health care legislation” does not include Act No. 218 of the Public Acts of 1956, as amended, being sections 500.100 to 500.8302 of the Michigan Compiled Laws.

(e) Comments received from an individual provider of the appropriate provider group, or from an organization or association that represents the appropriate provider class, and comments received pursuant to section 505(2).

(5) In making a determination pursuant to subsection (1), the commissioner shall provide a detailed statement of findings which support that determination, including a consideration of the information and factors described in subsection (4).

(6) All data, analyses, and factors, quantified or otherwise, at a minimum, shall include the 2-year period being evaluated.

(7) The commissioner shall make a sufficient number of determinations regarding provider class plans under this section, so that during each 3-year period following the effective date of this act, there is a review of provider class plans which, taken together, account for at least 75% of the total corporation payout to providers for the 3-year period.

(8) Determinations by the commissioner shall not be contested case hearings under chapter 4 of the administrative procedures act. This subsection shall not be construed to apply with respect to appeals under section 515.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1510 Additional determinations by commissioner.

Sec. 510. (1) After considering the information and factors described in section 509(4), the goals of a health care corporation as provided in section 504, and the objectives contained in the provider class plan, the commissioner shall determined 1 of the following:

(a) That the provider class plan achieves the goals of the corporation as provided in section 504.

(b) That although the provider class plan does not substantially achieve 1 or more of the goals of the corporation, a change in the provider class plan is not required because there has been competent, material, and substantial information obtained or submitted to support a determination that the failure to achieve 1 or more of the goals was reasonable due to factors listed in section 509(4).

(c) That a provider class plan does not substantially achieve 1 or more of the goals of the corporation as provided in section 504.

(2) The commissioner shall notify the health care corporation, and each person who has requested a copy of such notice, of a determination under subsection (1) by certified or registered mail. Determinations made pursuant to subsection (1)(b) or (c) shall include a concise written statement of specific findings supporting that determination.

(3) An existing provider contract or reimbursement arrangement shall remain in effect until a new provider class plan has been retained and placed into effect as provided in section 506(4). A provider class plan shall not be subject to further review until the expiration of the time period provided in section 509(1).

(4) A provider class plan with respect to which a determination was made under subsection (1)(a) or (b) shall not be subject to further review until the expiration of 2 years following the determination.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Compiler's note: Near the end of subsection (1), "determined" should read "determine."

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1511 Provider class plan; transmittal to commissioner; preparation by commissioner.

Sec. 511. (1) Upon receipt of notice under section 510(2), the health care corporation, within 6 months or a period determined by the commissioner pursuant to section 512, shall transmit to the commissioner a provider class plan that substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings made by the commissioner pursuant to section 510(2). In developing a provider class plan under this subsection, the corporation shall obtain advice and consultation from providers in the provider class and subscribers, using procedures established pursuant to section 505.

(2) If, after the expiration of 6 months or a period determined by the commissioner pursuant to section 512, the health care corporation has failed to act pursuant to subsection (1), the commissioner shall prepare a provider class plan pursuant to section 513(2)(a), for that provider class.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1512 Extension of 6-month period provided in § 550.511(1); determination.

Sec. 512. The commissioner may extend the 6-month period provided in section 511(1) once, for not more than 90 days, if the commissioner determines that a health care corporation requires additional time to assess the findings made by the commissioner or to prepare a provider class plan that substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings. In making a determination under this section, the commissioner shall consider the number of provider class plans, the extent of the changes to each plan, and the stage of development of each plan being prepared by the health care corporation pursuant to section 511(1).

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1513 Provider class plan; examination; automatic retention; placing plan into effect; preparation of plan by commissioner; notice.

Sec. 513. (1) Upon receipt of a provider class plan under section 511(1), the commissioner, after considering the information and factors described in section 509(4), within 90 days shall examine the plan and determine if the plan substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings made by the commissioner. If the commissioner determines that the plan substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings made by the commissioner, the plan shall be automatically retained and placed into effect as provided in section 506.

(2) If the commissioner determines that the plan does not substantially achieve the goals, does not achieve the objectives, and does not substantially overcome the deficiencies enumerated in the findings made by the

commissioner pursuant to section 510(2), the commissioner shall do all of the following:

(a) Prepare a provider class plan that substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings made pursuant to section 510(2), and transmit that plan to the health care corporation. A provider class plan prepared pursuant to this subdivision shall be retained for the commissioner's records and placed into effect as provided in section 506(4), unless a request for an appeal is made under subdivision (b).

(b) Give written notice to the health care corporation of an opportunity for an appeal pursuant to section 515. The notice shall state that a request for an appeal shall be made by the corporation within 30 days after the receipt of notice under this subdivision.

(3) In making a determination pursuant to subsection (1), or preparing a plan pursuant to subsection (2)(a), the commissioner shall obtain advice and consultation pursuant to section 505(2). The commissioner shall also forward a copy of each notice issued under subsection (2)(b) to each person requesting a copy. The copy shall notify the person of an opportunity for an appeal pursuant to section 515, and that a request for such an appeal is required to be made within 30 days after the receipt of notice given under this subsection.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1514 Appeal; selection and qualifications of hearing officer; consolidation; annual report.

Sec. 514. (1) All appeals under this part shall be held before an independent hearing officer. The state court administrator shall compile and maintain a list of individuals possessing all of the following qualifications:

(a) Is a retired circuit court judge.

(b) Is a resident of this state.

(c) Is not engaged in the provision of health care services.

(d) Is not an officer or employee of a health care provider, health care corporation, or an employee of this state. For purposes of this subdivision, an employee of an educational institution shall not be considered to be employed by this state.

(2) The hearing officer shall be selected at random by the commissioner from the list described in subsection (1), on a per appeal basis. If the individual selected is performing judicial duties, another individual shall be selected.

(3) The hearing officer shall have the power to consolidate appeals related to a provider class.

(4) The commissioner shall prepare and file with the appropriate standing committees of the legislature an annual report regarding the operation of the appeals procedure prescribed in this part, including data regarding the identity of individuals available to serve as independent hearing officers whose names are on the administrator's list; the number of appeals heard; the nature of the controversy involved; the disposition of the appeal; and whether a judicial appeal was subsequently taken, and the disposition of that appeal.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1515 Appeal; parties; request; time; relief; transmittal of provider class plan to hearing officer; determinations.

Sec. 515. (1) An appeal may be brought from any action or determination of the commissioner under section 509(1), 510(1), or 513(1) or (2), by a subscriber, the health care corporation, the attorney general, an employer, an organization or association representing a subscriber or an employer, or an organization or association representing the affected provider class. An appeal may also be brought by a person whose contractual or legal rights, duties, or privileges are substantially affected. The request for an appeal shall identify the issue or issues which the affected party asserts are involved, and how the party is aggrieved. The independent hearing officer shall determine the standing of any party to appeal.

(2) An appeal from an action or determination of the commissioner under this part shall be brought within 30 days after the action or determination. All appeal hearings shall begin within 30 days after receipt of a request for an appeal. The appeal shall be conducted pursuant to chapter 4 of the administrative procedures act.

(3) In an appeal pursuant to this section, the relief available to a person, and the decision of an independent hearing officer hearing an appeal, shall be limited to the following:

(a) Affirming or reversing a determination of the commissioner under sections 509(1) and 510(1).

(b) Determining, based on the information and factors described in section 509(4) and the standards prescribed in

section 516, 1 of the following:

(*i*) That the provider class plan prepared by the corporation under section 511(1) was prepared in compliance with that section and shall be retained as provided in section 506(4).

(*ii*) That the provider class plan prepared by the commissioner under section 513(2)(a) was prepared in compliance with that section and shall be retained as provided in section 506(4).

(*iii*) That a provider class plan described in subparagraph (*i*) or (*ii*) was not prepared in compliance with section 511(1) or 513(2)(a), respectively, and shall not be retained as provided in section 506(4). In this case, the hearing officer shall order the corporation to prepare and submit a provider class plan as provided in subsection (4). Detailed findings must accompany the determination made by the hearing officer pursuant to this subdivision.

(4) Within 180 days after receipt of the hearing officer's determination made under subsection (3)(b)(*iii*), the health care corporation shall transmit to the hearing officer a provider class plan that is in conformance with the findings of the hearing officer and that substantially achieves the goals of a health care corporation as provided in section 504. In developing a provider class plan under this subsection, the corporation shall obtain advice and consultation from providers in the provider class and subscribers, using procedures established pursuant to section 505.

(5) After receipt of a provider class plan transmitted by the health care corporation pursuant to subsection (4), the hearing officer shall determine 1 of the following:

(a) That the provider class plan prepared by the corporation shall be retained as provided in section 506(4).

(b) That the provider class plan prepared by the corporation should not be retained as provided in section 506(4), and the commissioner may suspend or limit the corporation's certificate of authority until the corporation submits a provider class plan which the hearing officer determines should be retained as provided in section 506(4).

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1516 Provider class plan; standards.

Sec. 516. (1) All provider class plans retained by the commissioner under section 513 or approved by the hearing officer shall maintain the following standards for all providers:

(a) Responsible cost controls shall exist that balance quality, accessibility, and cost.

(b) The health care corporation shall promote programs and policies which encourage cost-effective behavior by providers in accordance with the provisions of this act, and in accordance with all of the following:

(*i*) There shall be a reasonable basis for believing that the programs will be effective.

(*ii*) The programs applicable to a provider class shall be reviewed to avoid duplication or inconsistency, to the extent practicable.

(c) There shall be a fair and reasonable appeals process established and maintained by the health care corporation for aggrieved providers.

(d) There shall be a reasonable period for implementation of changes.

(e) There shall be reasonably prompt payment by the health care corporation to providers who render covered health care services.

(2) In addition to the standards prescribed in subsection (1), the following standards shall apply to hospitals:

(a) To the extent practicable, reimbursement control shall be expressed in the aggregate to individual hospitals.

(b) No portion of the health care corporation's fair share of hospitals' reasonable financial requirements shall be borne by other health care purchasers. However, this subdivision shall not preclude reimbursement arrangements which include financial incentives and disincentives.

(c) The health care corporation's programs and policies shall not unreasonably interfere with the hospital's ability and responsibility to manage its operations.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1517 Annual report.

Sec. 517. A health care corporation shall transmit an annual report for each provider class to the commissioner regarding the level of achievement of the goals provided in section 504. The report shall include data necessary to a determination of the corporation's compliance or noncompliance with the goals, as prescribed in section 504, and compliance with objectives contained in the provider class plan. The report shall be in accordance with forms and

instructions prescribed by the commissioner and shall include information as necessary to evaluate the considerations of section 509(4). The report may include other information the corporation deems relevant.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1518 Considerations and standards; applicability; appeal.

Sec. 518. The considerations set forth in section 509(4) and the standards set forth in section 516 shall only apply for purposes of this act and may be appealed only as specifically provided in this act. An appeal from a final determination of an independent hearing officer shall be conducted pursuant to chapter 6 of the administrative procedures act, except that the appeal shall be taken within 30 days after the final determination, upon leave granted, in the court of appeals.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

PART 6

550.1601 Regulation and supervision of health care corporation; delegation of authority.

Sec. 601. (1) A health care corporation shall be subject to regulation and supervision by the commissioner as provided in this act.

(2) A designee of the commissioner shall not be authorized to act on behalf of the commissioner under this act unless prior written notice of the delegation of authority has been given to a health care corporation subject to that delegated authority.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1602 Statement of condition; statistical, financial, and other reports.

Sec. 602. (1) Not later than March 1 each year, subject to a 30-day extension that may be granted by the commissioner, a health care corporation shall file in the office of the commissioner a sworn statement verified by at least 2 of the principal officers of the corporation showing its condition as of the preceding December 31. The statement shall be in a form and contain those matters that the commissioner prescribes for a health care corporation, including those matters contained in section 204a. The statement shall include the number of members and the number of subscribers' certificates issued by the corporation and outstanding.

(2) The commissioner, by order, may require a health care corporation to submit statistical, financial, and other reports for the purpose of monitoring compliance with this act.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 2003, Act 59, Eff. July 23, 2003.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1603 Visitation and examination; access to books, papers, and documents; witnesses; expenses; disclosure of information; reporting violation; action by attorney general; ex parte order directing compliance.

Sec. 603. (1) The commissioner may visit and examine the affairs of a health care corporation. The corporation shall in every way facilitate an examination or visitation.

(2) The power of examination shall include free access to all of the books, papers, and documents that relate to the business of the corporation, except as provided in section 304(2)(d). Free access shall include the right to copy and reproduce at the place of business of the health care corporation and to require delivery of any materials to the office of the commissioner in Lansing within 5 working days after the request is made. If the corporation is unable to respond to the request within 5 working days, the corporation shall specify a date certain by which the corporation will respond. However, the date certain shall not be later than 15 working days after the request is made unless the commissioner agrees to a longer period of time. Witnesses may be summoned and qualified under oath, and examination may be made of the corporation's officers, agents, or employees or of other persons having

knowledge of the affairs, transactions, and conditions of the corporation. Except as provided in section 603a, the per diem, traveling, reproduction, and other necessary expenses in connection with visitation and examination shall be paid by the corporation and shall be credited to the general fund of the state.

(3) Information provided to the commissioner that is disclosable only to the commissioner under section 304(2) shall not be disclosed by the commissioner to other persons until such time as the minutes pertaining to that information may be disclosed under section 304(3).

(4) If it appears from any examination or report that this act or any other law of this state has been violated, the commissioner immediately shall report the violation to the attorney general in writing. The attorney general shall then take action on the alleged violation, as the facts warrant. Unless the public health, safety, or welfare otherwise clearly requires, before commencement of a proceeding against a health care corporation resulting from a report, the corporation shall be furnished a copy of the examination report and shall be given an informal opportunity to show compliance with the law.

(5) Upon the request of the commissioner, the attorney general may petition for, and the circuit court may issue, an ex parte order from the circuit court directing a corporation to comply with this section. The corporation shall be entitled to an expedited hearing to challenge the ex parte order.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1994, Act 169, Imd. Eff. June 17, 1994.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1603a Health care corporation subject to §§ 500.224 and 500.225; costs and expenses.

Sec. 603a. A health care corporation is subject to sections 224(4) through (13) and 225 of the insurance code of 1956, Act No. 218 of the Public Acts of 1956, being sections 500.224 and 500.225 of the Michigan Compiled Laws, instead of the costs and expenses that may be imposed by the commissioner pursuant to section 603.

History: Add. 1994, Act 169, Imd. Eff. June 17, 1994.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1604 Confidentiality; violation as misdemeanor; penalty.

Sec. 604. (1) The commissioner shall ensure that confidentiality of records containing personal data which may be associated with identifiable individuals. Except as is necessary to comply with a court order, or for the purposes of claim adjudication or when required by law, the commissioner shall not disclose records containing personal data which may be associated with an identifiable individual without the prior informed consent of the individual to whom the data pertain. The individual's consent shall be in writing. If an individual has authorized the release of personal data to a specific person, that person shall not release the data to a third person unless the individual executes in writing another informed consent authorizing that additional release.

(2) The commissioner shall ensure the confidentiality of data which discloses reimbursement levels for specific procedures or services of specific providers and data which, if disclosed, can be used to calculate those reimbursement levels. This subsection shall apply only if the data are not already generally known to providers and if the disclosure of the data would be harmful to the achievement of the goals set forth in section 504. Only that portion of a record dealing with data described in this subsection shall be exempt from disclosure. A person, whose request for a hearing has been granted by the commissioner, may examine the data and shall be subject to the same confidentiality requirements as the commissioner under this subsection.

(3) The commissioner shall ensure the confidentiality of any trade secrets of the corporation, except for information required to be disclosed under Act No. 442 of the Public Acts of 1976, as amended, being sections 15.231 to 15.246 of the Michigan Compiled Laws.

(4) Subject to the provisions of subsections (1) to (3), information which a health care corporation provides to or files with the commissioner shall be governed by Act No. 442 of the Public Acts of 1976, as amended, being sections 15.231 to 15.246 of the Michigan Compiled Laws.

(5) A person who violates the confidentiality provisions of this section is guilty of a misdemeanor, punishable by a fine of not more than $1,000.00 for each violation.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1605 Certificate of authority; suspension or limitation; circumstances; order; hearing; notice.

Sec. 605. (1) Upon due notice and an opportunity for an evidentiary hearing pursuant to the administrative

procedures act, the commissioner may suspend or limit the certificate of authority of a health care corporation if the commissioner determines that any of the following circumstances exist:

(a) The health care corporation does not meet the requirements of this act respecting the adequacy of its reserves.

(b) The health care corporation is using methods or practices in the conduct of its business which render further transactions hazardous or injurious to subscribers of the corporation or the public.

(c) The health care corporation refuses or fails to comply with this act or with a lawful order of the commissioner.

(2) If the commissioner finds that the public health, safety, or welfare requires emergency action and incorporates this finding into an order, a summary suspension or limitation of a certificate of authority may be ordered. The suspension or limitation shall be effective on the date specified in the order or upon service of a certified copy of the order on the health care corporation, whichever is later, and shall be effective during the proceedings. The corporation shall have the right to an administrative hearing within 5 days to show why the summary suspension or limitation should be terminated.

(3) An order of limitation may restrict the solicitation of certificates, the renewal of business in force, and the solicitation, offer, or acceptance of contracts, and may impose other conditions to continued authorization as are reasonably necessary to protect the subscribers of the corporation or the public. The commissioner shall terminate an order of limitation when the circumstance giving rise to the order ceases to exist.

(4) Upon suspension or limitation of a corporation's certificate of authority, if the commissioner considers it necessary or desirable for the protection of the subscribers of the corporation or the public, the commissioner may publish notice of the suspension or limitation in 1 or more newspapers of general circulation in the state.

(5) An emergency order by the commissioner which suspends or limits a corporation's certificate of authority shall be for a period not to exceed 1 year and, after opportunity of hearing, the commissioner for good cause may extend the period of suspension or limitation for additional periods not to exceed 1 year.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1606 Authority of commissioner regarding officers and directors; authority as to dissolution, taking over, or liquidation of corporations; insolvency defined.

Sec. 606. (1) The commissioner shall have the same authority regarding the officers and directors of a health care corporation as the commissioner has with respect to the officers and directors of insurers under sections 249 and 250 of the insurance code of 1956, 1956 PA 218, MCL 500.249 and 500.250.

(2) The commissioner shall have the same authority with respect to the dissolution, taking over, or liquidation of corporations formed or doing business under this act as is provided in chapter 81 of the insurance code of 1956, 1956 PA 218, MCL 500.8101 to 500.8159. For purposes of this subsection, a health care corporation shall be considered to be insolvent if its liabilities exceed its assets, unless otherwise defined in chapter 81 of the insurance code of 1956, 1956 PA 218, MCL 500.8101 to 500.8159.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 2003, Act 59, Eff. July 23, 2003.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1607 Submission of new or revised certificate and applicable proposed rates; approval or disapproval; exemption; circumstances and conditions; notice; implementation of certificates and rates.

Sec. 607. (1) A health care corporation shall submit a copy of any new or revised certificate to the commissioner along with applicable proposed rates and rate rationale. The certificates, and applicable proposed rates, shall be deemed approved and effective 30 days after filing with the commissioner, except as otherwise provided in this section. The commissioner may subsequently disapprove any certificate deemed approved.

(2) The commissioner shall exempt from prior approval certificates resulting from a collective bargaining agreement.

(3) The commissioner may disapprove, or approve with modifications, a certificate and applicable rates under 1 or more of the following circumstances:

(a) If the rate charged for the benefits provided is not equitable, not adequate, or excessive, as defined in section 609.

(b) If the certificate contains 1 or more provisions which are unjust, unfair, inequitable, misleading, deceptive, or

which encourage misrepresentation of the coverage.

(c) If a certificate reduces the scope, amount, or duration of benefits so as to have the effect of reducing the comprehensiveness of existing health care benefits available to groups or to individuals. The commissioner may approve a certificate which reduces the scope, amount, or duration of health care benefits if the commissioner determines that the certificate will be offered as an alternative in addition to an existing certificate which provides comprehensive health care benefits and if the commissioner determines that approval of the alternative certificate will not adversely affect the opportunity for groups or individuals to obtain comprehensive health care benefits.

(4) The commissioner shall approve a certificate and applicable proposed rates if all of the following conditions are met:

(a) If the rate charged for the benefits provided is equitable, adequate, and not excessive, as defined in section 609.

(b) If the certificate does not contain any provision which is unjust, unfair, inequitable, misleading, deceptive, or which encourages misrepresentation of the coverage.

(5) If the commissioner disapproves a certificate and any applicable proposed rates under this section, he or she shall issue a notice of disapproval which specifies in what respects a filing fails to meet the requirements of this act. The notice shall state that the filing shall not become effective.

(6) If the commissioner approves, or approves with modifications, a certificate and any applicable proposed rates under this section, he or she shall issue a notice of approval or approval with modifications. If the notice is of approval with modifications, the notice shall specify what modifications in the filing are required for approval under this act, and the reasons for the modifications. The notice shall also state that the filing shall become effective after the modifications are made and approved by the commissioner.

(7) Upon request by a health care corporation, the commissioner may allow certificates and rates to be implemented prior to filing to allow implementation of a new certificate on the date requested.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Constitutionality: This act is unconstitutional in the following three particulars:

The Supreme Court ruling on these three areas of this act does not affect the constitutionality of the remainder of the act. Where, as here, the unconstitutional provisions are easily severable, the remainder of the act need not be affected. Blue Cross and Blue Shield of Michigan v. Governor, 422 Mich. 1 (1985).

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1608 Rates charged to nongroup subscribers for certificate; methodology and definitions of rating system, formula, component, and factor used to calculate rates for group subscribers for certificate; filing; approval, disapproval, or modification; standard; burden of proof; effective date of proposed rate; rate adjustments; implementation prior to approval; examination of financial arrangement; formulae, and factors.

Sec. 608. (1) The rates charged to nongroup subscribers for each certificate shall be filed in accordance with section 610 and shall be subject to the prior approval of the commissioner. Annually, the commissioner shall approve, disapprove, or modify and approve the proposed or existing rates for each certificate subject to the standard that the rates must be determined to be equitable, adequate, and not excessive, as defined in section 609. The burden of proof that rates to be charged meet these standards shall be upon the health care corporation proposing to use the rates.

(2) The methodology and definitions of each rating system, formula, component, and factor used to calculate rates for group subscribers for each certificate, including the methodology and definitions used to calculate administrative costs for administrative services only and cost-plus arrangements, shall be filed in accordance with section 610 and shall be subject to the prior approval of the commissioner. The definition of a group, including any clustering principles applied to nongroup subscribers or small group subscribers for the purpose of group formation, shall be subject to the prior approval of the commissioner. However, if a Michigan caring program is created under section 436, that program shall be defined as a group program for the purpose of establishing rates. The commissioner shall approve, disapprove, or modify and approve the methodology and definitions of each rating system, formula, component, and factor for each certificate subject to the standard that the resulting rates for group subscribers must be determined to be equitable, adequate, and not excessive, as defined in section 609. In addition, the commissioner may from time to time review the records of the corporation to determine proper application of a rating system, formula, component, or factor with respect to any group. The corporation shall refile for approval under this subsection, every 3 years, the methodology and definitions of each rating system, formula, component, and factor used to calculate rates for group subscribers, including the methodology and definitions used to calculate

administrative costs for administrative services only and cost-plus arrangements. The burden of proof that the resulting rates to be charged meet these standards shall be upon the health care corporation proposing to use the rating system, formula, component, or factor.

(3) A proposed rate shall not take effect until a filing has been made with the commissioner and approved under section 607 or this section, as applicable, except as provided in subsections (4) and (5).

(4) Upon request by a health care corporation, the commissioner may allow rate adjustments to become effective prior to approval, for federal or state mandated benefit changes. However, a filing for these adjustments shall be submitted before the effective date of the mandated benefit changes. If the commissioner disapproves or modifies and approves the rates, an adjustment shall be made retroactive to the effective date of the mandated benefit changes or additions.

(5) Implementation prior to approval may be allowed if the health care corporation is participating with 1 or more health care corporations to underwrite a group whose employees are located in several states. Upon request from the commissioner, the corporation shall file with the commissioner, and the commissioner shall examine, the financial arrangement, formulae, and factors. If any are determined to be unacceptable, the commissioner shall take appropriate action.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1991, Act 73, Imd. Eff. July 11, 1991.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1609 Excessive rate; administrative expense budget; equitable rate; adequate rate; line of business to be self-sustaining; cost transfers for benefit of senior citizens and group conversion subscribers.

Sec. 609. (1) A rate is not excessive if the rate is not unreasonably high relative to the following elements, individually or collectively; provision for anticipated benefit costs; provision for administrative expense; provision for cost transfers, if any; provision for a contribution to or from surplus that is consistent with the attainment or maintenance of adequate and unimpaired surplus as provided in section 204a; and provision for adjustments due to prior experience of groups, as defined in the group rating system. A determination as to whether a rate is excessive relative to these elements, individually or collectively, shall be based on the following: reasonable evaluations of recent claim experience; projected trends in claim costs; the allocation of administrative expense budgets; and the present and anticipated unimpaired surplus of the health care corporation. To the extent that any of these elements are considered excessive, the provision in the rates for these elements shall be modified accordingly.

(2) The administrative expense budget must be reasonable, as determined by the commissioner after examination of material and substantial administrative and acquisition expense items.

(3) A rate is equitable if the rate can be compared to any other rate offered by the health care corporation to its subscribers, and the observed rate differences can be supported by differences in anticipated benefit costs, administrative expense cost, differences in risk, or any identified cost transfer provisions.

(4) A rate is adequate if the rate is not unreasonably low relative to the elements prescribed in subsection (1), individually or collectively, based on reasonable evaluations of recent claim experience, projected trends in claim costs, the allocation of administrative expense budgets, and the present and anticipated unimpaired surplus of the health care corporation.

(5) Except for identified cost transfers, each line of business, over time, shall be self-sustaining. However, there may be cost transfers for the benefit of senior citizens and group conversion subscribers. Cost transfers for the benefit of senior citizens, in the aggregate, annually shall not exceed 1% of the earned subscription income of the health care corporation as reported in the most recent annual statement of the corporation. Group conversion subscribers are those who have maintained coverage with the health care corporation on an individual basis after leaving a subscriber group.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1991, Act 61, Eff. July 11, 1991;—Am. 2003, Act 59, Eff. July 23, 2003.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1610 Filing of information and materials relative to proposed rate; notice; approval, approval with modifications, or disapproval; additional information and materials; determination; notice; visitation and examination; expenses; order; effect of inability to approve 1 or more rating classes of business within line of business; information in support of nongroup rate filing; public inspection of information; forms and instructions for filing proposed rates.

Sec. 610. (1) Except as provided under section 608(4) or (5), a filing of information and materials relative to a proposed rate shall be made not less than 120 days before the proposed effective date of the proposed rate. A filing shall not be considered to have been received until there has been substantial and material compliance with the requirements prescribed in subsections (6) and (8).

(2) Within 30 days after a filing is made of information and materials relative to a proposed rate, the commissioner shall do either of the following:

(a) Give written notice to the corporation, and to each person described under section 612(1), that the filing is in material and substantial compliance with subsections (6) and (8) and that the filing is complete. The commissioner shall then proceed to approve, approve with modifications, or disapprove the rate filing 60 days after receipt of the filing, based upon whether the filing meets the requirements of this act. However, if a hearing has been requested under section 613, the commissioner shall not approve, approve with modifications, or disapprove a filing until the hearing has been completed and an order issued.

(b) Give written notice to the corporation that the corporation has not yet complied with subsections (6) and (8). The notice shall state specifically in what respects the filing fails to meet the requirements of subsections (6) and (8).

(3) Within 10 days after the filing of notice pursuant to subsection (2)(b), the corporation shall submit to the commissioner such additional information and materials, as requested by the commissioner. Within 10 days after receipt of the additional information and materials, the commissioner shall determine whether the filing is in material and substantial compliance with subsections (6) and (8). If the commissioner determines that the filing does not yet materially and substantially meet the requirements of subsections (6) and (8), the commissioner shall give notice to the corporation pursuant to subsection (2)(b) or use visitation of the corporation's facilities and examination of the corporation's records to obtain the necessary information described in the notice issued pursuant to subsection (2)(b). The commissioner shall use either procedure previously mentioned, or a combination of both procedures, in order to obtain the necessary information as expeditiously as possible. The per diem, traveling, reproduction, and other necessary expenses in connection with visitation and examination shall be paid by the corporation, and shall be credited to the general fund of the state.

(4) If a filing is approved, approved with modifications, or disapproved under subsection (2)(a), the commissioner shall issue a written order of the approval, approval with modifications, or disapproval. If the filing was approved with modifications or disapproved, the order shall state specifically in what respects the filing fails to meet the requirements of this act and, if applicable, what modifications are required for approval under this act. If the filing was approved with modifications, the order shall state that the filing shall take effect after the modifications are made and approved by the commissioner. If the filing was disapproved, the order shall state that the filing shall not take effect.

(5) The inability to approve 1 or more rating classes of business within a line of business because of a requirement to submit further data or because a request for a hearing under section 613 has been granted shall not delay the approval of rates by the commissioner which could otherwise be approved or the implementation of rates already approved, unless the approval or implementation would affect the consideration of the unapproved classes of business.

(6) Information furnished under subsection (1) in support of a nongroup rate filing shall include the following:

(a) Recent claim experience on the benefits or comparable benefits for which the rate filing applies.

(b) Actual prior trend experience.

(c) Actual prior administrative expenses.

(d) Projected trend factors.

(e) Projected administrative expenses.

(f) Contributions for risk and contingency reserve factors.

(g) Actual health care corporation contingency reserve position.

(h) Projected health care corporation contingency reserve position.

(i) Other information which the corporation considers pertinent to evaluating the risks to be rated, or relevant to the determination to be made under this section.

(j) Other information which the commissioner considers pertinent to evaluating the risks to be rated, or relevant to the determination to be made under this section.

(7) A copy of the filing, and all supporting information, except for the information which may not be disclosed under section 604, shall be open to public inspection as of the date filed with the commissioner.

(8) The commissioner shall make available forms and instructions for filing for proposed rates under sections 608(1) and 608(2). The forms with instructions shall be available not less than 180 days before the proposed

effective date of the filing.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1611 Legislative intent.

Sec. 611. It is the intent of the legislature to promote uniformity of rates among subscribers to the greatest extent practicable.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1612 Notice of rate filing; contents of request for hearing; advertisements; limitation on fee for copy of rate filing; waiver or reduction of fee; calculation of costs.

Sec. 612. (1) Upon receipt of a rate filing under section 610, the commissioner immediately shall notify each person who has requested in writing notice of those filings within the previous 2 years, specifying the nature and extent of the proposed rate revision and identifying the location, time, and place where the copy of the rate filing described in section 610(7) shall be open to public inspection and copying. The notice shall also state that if the person has standing, the person shall have, upon making a written request for a hearing within 60 days after receiving notice of the rate filing, an opportunity for an evidentiary hearing under section 613 to determine whether the proposed rates meet the requirements of this act. The request shall identify the issues which the requesting party asserts are involved, what portion of the rate filing is requested to be heard, and how the party has standing. The corporation shall place advertisements giving notice, containing the information specified above, in at least 1 newspaper which serves each geographic area in which significant numbers of subscribers reside.

(2) The commissioner may charge a fee for providing, pursuant to subsection (1), a copy of the rate filing described in section 610(7). The commissioner may charge a fee for providing a copy of the entire filing to a person whose request for a hearing has been granted by the commissioner pursuant to section 613. The fee shall be limited to actual mailing costs and to the actual incremental cost of duplication, including labor and the cost of deletion and separation of information as provided in section 14 of Act No. 442 of the Public Acts of 1976, being section 15.244 of the Michigan Compiled Laws. Copies of the filing may be provided free of charge or at a reduced charge if the commissioner determines that a waiver or reduction of the fee is in the public interest because the furnishing of a copy of the filing will primarily benefit the general public. In calculating the costs under this subsection, the commissioner shall not attribute more than the hourly wage of the lowest paid, full-time clerical employee of the insurance bureau to the cost of labor incurred in duplication and mailing and to the cost of separation and deletion. The commissioner shall use the most economical means available to provide copies of a rate filing.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1613 Request for hearing; standing of person; access to filing; confidentiality; penalty; appointment and qualifications of independent hearing officer; commencement of hearing; discovery; conducting hearing; burden of proving compliance; factors in rendering proposal for decision; order rendering decision; withdrawal of order.

Sec. 613. (1) If the request for a hearing under this section is with regard to a rate filing not yet acted upon under section 610(2)(a), no such action shall be taken by the commissioner until after the hearing has been completed. However, the commissioner shall proceed to act upon those portions of a rate filing upon which no hearing has been requested. Within 15 days after receipt of a request for a hearing, the commissioner shall determine if the person has standing. If the commissioner determines that the person has standing, the person may have access to the entire filing subject to the same confidentiality requirements as the commissioner under section 604, and shall be subject to the penalty provision of section 604(5). Upon determining that the person has standing, the commissioner shall immediately appoint an independent hearing officer before whom the hearing shall be held. In appointing an independent hearing officer, the commissioner shall select a person qualified to conduct hearings, who has experience or education in the area of health care corporation or insurance rate determination and finance, and who is not otherwise associated financially with a health care corporation or a health care provider. The person selected shall not be currently or actively employed by this state. For purposes of this subsection, an employee of an educational institution shall not be considered to be employed by this state. For purposes of this section, a person

has "standing" if any of the following circumstances exist:

(a) The person is, or there are reasonable grounds to believe that the person could be, aggrieved by the proposed rate.

(b) The person is acting on behalf of 1 or more named persons described in subdivision (a).

(c) The person is the commissioner, the attorney general, or the health care corporation.

(2) Not more than 30 days after receipt of a request for a hearing, and upon not less than 15 days' notice to all parties, the hearing shall be commenced. Each party to the hearing shall be given a reasonable opportunity for discovery before and throughout the course of the hearing. However, the hearing officer may terminate discovery at any time, for good cause shown. The hearing officer shall conduct the hearing pursuant to the administrative procedures act. The hearing shall be conducted in an expeditious manner. At the hearing, the burden of proving compliance with this act shall be upon the health care corporation.

(3) In rendering a proposal for a decision, the hearing officer shall consider the factors prescribed in section 609.

(4) Within 30 days after receipt of the hearing officer's proposal for decision, the commissioner shall by order render a decision which shall include a statement of findings.

(5) The commissioner shall withdraw an order of approval or approval with modifications if the commissioner finds that the filing no longer meets the requirements of this act.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1614 Interim rates; petition; determination; granting interim rate; final rate determination; refunds or adjustments; limitation on order establishing interim rate adjustment; rates to which section applicable.

Sec. 614. (1) Not less than 75 days after a filing is received, as provided in section 610, the health care corporation may petition the commissioner, who shall make a determination with respect to interim rates and shall order interim rates in the amount prescribed in subsection (2). Interim rates shall not be implemented if the commissioner finds that the health care corporation has substantially contributed to the delay or that the health care corporation has not provided information requested by the commissioner relative to a determination under this section. The interim rate determination shall not be a contested case under chapter 4 of the administrative procedures act.

(2) The commissioner shall grant an interim rate, in an amount as determined by the commissioner, if the commissioner makes a finding that the corporation has made a convincing showing that there is probable cause to believe that the failure to grant the interim rate will result in an underwriting loss for that line of business for the period for which rates are being requested. As used in this subsection, "underwriting loss" means the difference between income from current rates plus investment income, and projected claims plus projected administrative expenses.

(3) If the final rate determination results in approval of a lower rate, appropriate refunds or adjustments, as determined by the commissioner, shall be made to reflect payments made in excess of the approved rate.

(4) The order establishing an interim rate adjustment made pursuant to this section shall be limited to adjusting rates for certificates then in effect, and shall not be used to alter certificates or implement new certificates.

(5) This section shall apply only to rates subject to section 608(1) for which a hearing has been requested.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1615 Review of final order or decision.

Sec. 615. Any final order or decision made, issued, or executed by the commissioner under this act after a hearing held before the commissioner or a deputy commissioner pursuant to the administrative procedures act shall be subject to review as provided in chapter 6 of the administrative procedures act without leave by the circuit court for Ingham county.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1616 Endorsing, filing, and indexing documents; notice of refusal to file; judicial review; certificate of correction; persons adversely affected by correction; documents to which section

inapplicable.

Sec. 616. (1) If a document required or permitted to be filed with the commissioner under this act substantially conforms to the requirements of this act, the commissioner shall endorse upon it the word "filed" with the commissioner's official title and the dates of receipt and of filing, and shall file and index the document or a reproduction of the document pursuant to the records media act in his or her office. If so requested at the time of delivery of the document to his or her office, the commissioner shall include the hour of filing in his or her endorsement on the document.

(2) If the commissioner fails promptly to file a document, other than an annual report or a supplemental statement, submitted for filing under this act, the commissioner, within 10 days after receipt from the person submitting the document for filing of a written request for the filing of the document, shall give written notice of the refusal to file to that person, specifying the reasons for the failure to file the document. From the disapproval, the person may seek judicial review pursuant to sections 103, 104, and 106 of the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.303, 24.304, and 24.306 of the Michigan Compiled Laws.

(3) If a document relating to a health care corporation filed with the commissioner under this act is an inaccurate record of the corporation action referred to in the document or was defectively or erroneously executed, the document may be corrected by filing with the commissioner a certificate of correction on behalf of the corporation. A certificate, entitled "certificate of correction of . . . (correct title of document and name of corporation)" shall be signed as provided in this act with respect to the document being corrected and shall be filed with the commissioner. The certificate shall set forth the name of the corporation, the date the document to be corrected was filed by the commissioner, the provision in the document as corrected or eliminated, and, if the execution was defective, the proper execution. The corrected document is effective in its corrected form as of its original filing date except as to a person who relied upon the inaccurate portion of the document and was, as a result of the inaccurate portion of the document, adversely affected by the correction.

(4) This section does not apply with respect to documents filed pursuant to part 5 or this part.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1992, Act 197, Imd. Eff. Oct. 5, 1992.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1617 Rules.

Sec. 617. The commissioner may promulgate rules which the commissioner considers necessary to carry out the purposes of, and to execute and enforce this act. The rules shall be promulgated pursuant to the administrative procedures act.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1618 Compliance with new procedures, benefits, or contracts.

Sec. 618. Whenever any section of this act requires a health care corporation to implement any new procedure, provide any new benefit, or enter into any new contract, the commissioner shall give the health care corporation a reasonable time to comply with the requirements.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1619 Injunction; declaratory and equitable relief; enforcement of act or rules.

Sec. 619. (1) The attorney general may bring an action, or apply to the circuit court for a court order, to enjoin a health care corporation from transacting business, receiving, collecting, or disbursing money, or acquiring, holding, protecting, or conveying property if that corporate activity is not authorized under this act.

(2) The attorney general may apply to the circuit court for a court order enjoining an alleged violation of this act or other equitable or extraordinary relief to enforce this act.

(3) A political subdivision of this state, an agency of this state, or any person may bring an action in the circuit court for Ingham county for declaratory and equitable relief against the commissioner or to compel the commissioner to enforce this act or rules promulgated under this act.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

PART 7

550.1701 Formal reorganization not required; duties of health care corporation; amendments to articles and bylaws; description of board restructuring; review; certification; statement of reasons for disapproval; judicial remedies; effect of noncompliance; extension of corporate existence; powers undiminished.

Sec. 701. (1) Each health care corporation on the effective date of this act shall be subject to this act without formal reorganization under this act, and shall be considered to exist under this act. However, within 120 days following the effective date of this act, the health care corporation shall do all of the following:

(a) Amend its articles of incorporation and bylaws to conform to the requirements of this act, subject to the certification of the attorney general, as provided in subsection (2).

(b) Restructure its board of directors to conform with the requirements of this act. The restructuring shall be described, shall be in writing, and shall be subject to the certification of the attorney general, as provided in subsection (2).

(c) After complying with subdivisions (a) and (b), obtain from the commissioner a new certificate of authority.

(2) Relative to the changes required by this act, amendments to the articles and bylaws, and a written description of the board restructuring shall be submitted to the attorney general and to the commissioner. If the attorney general finds that the amendments and restructuring conform to all statutory requirements, and that they comply with this act and ensure fair and equitable representation of the subscribers of the corporation, the attorney general shall certify these findings to the commissioner. In reviewing the amendments and description of the board restructuring, the attorney general may consult with the board of directors, officers, or employees of a corporation, and with any other individual or organization.

(3) If the attorney general approves the amendments and restructuring, the attorney general shall certify his or her approval to the board. The amendments, and restructuring as described, shall take effect 10 days after the certification. If the attorney general disapproves all or any part of the amendments or restructuring, or both, the attorney general shall return the disapproved amendments or the written description of the restructuring, or both, to the board with a written statement setting forth the reasons for the disapproval and any recommendations for change which he or she may wish to suggest.

(4) If the amendments, written description of restructuring, or both, required by this act are not submitted to the attorney general and the commissioner within 120 days after the effective date of this act, or if the amendments, written description, or both, are disapproved as provided in this section, the commissioner and the attorney general shall, and the corporation may, seek judicial remedies as provided for by law in the circuit court in this state.

(5) If a health care corporation fails to comply with this section, the commissioner may issue an order suspending the right and privilege of the corporation to sell or issue new certificates until this section has been fully complied with.

(6) The corporate existence of each health care corporation operating in this state shall be considered to be extended, and its powers in all other respects undiminished, during the 120-day implementation period prescribed in subsection (1).

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1702 Discontinuation of certain rules; continuation of certain orders and approvals.

Sec. 702. Rules which were promulgated under former Act No. 108 or 109 of the Public Acts of 1939, shall not continue in effect under this act. Orders issued and approvals granted by the commissioner under former Act No. 108 or 109 of the Public Acts of 1939, shall continue in effect until rescinded or withdrawn by the commissioner under this act.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Compiler's note: Acts 108 and 109 of 1939, referred to in this section, were repealed by Act 350 of 1980.
Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1703 Repeal of §§ 550.301 to 550.316 and 550.501 to 550.517.

Sec. 703. The following acts and parts of acts are repealed:

(a) Act No. 108 of the Public Acts of 1939, as amended, being sections 550.301 to 550.316 of the Compiled Laws of 1970.

(b) Act No. 109 of the Public Acts of 1939, as amended, being sections 550.501 to 550.517 of the Compiled Laws of 1970.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

550.1704 Effective date.

Sec. 704. This act shall take effect April 3, 1981.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield
Popular name: Act 350

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